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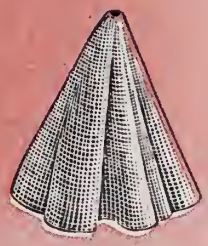
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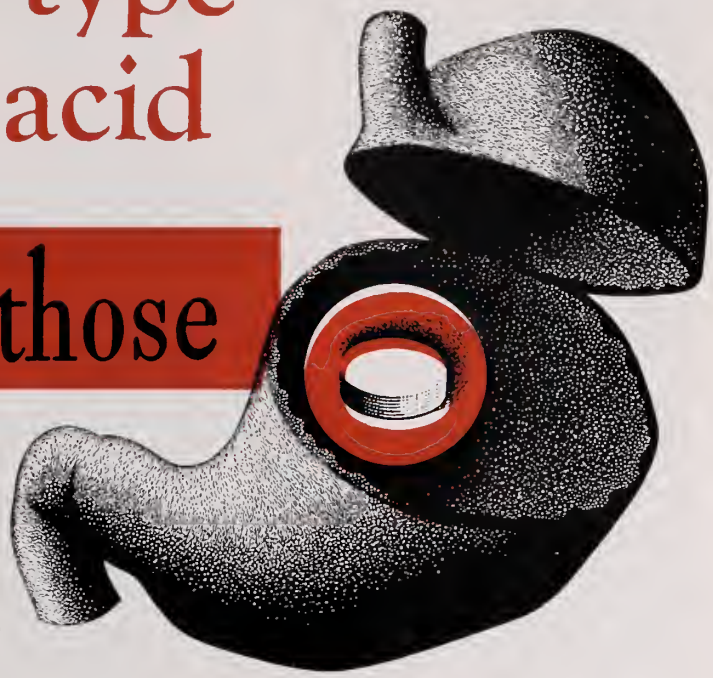
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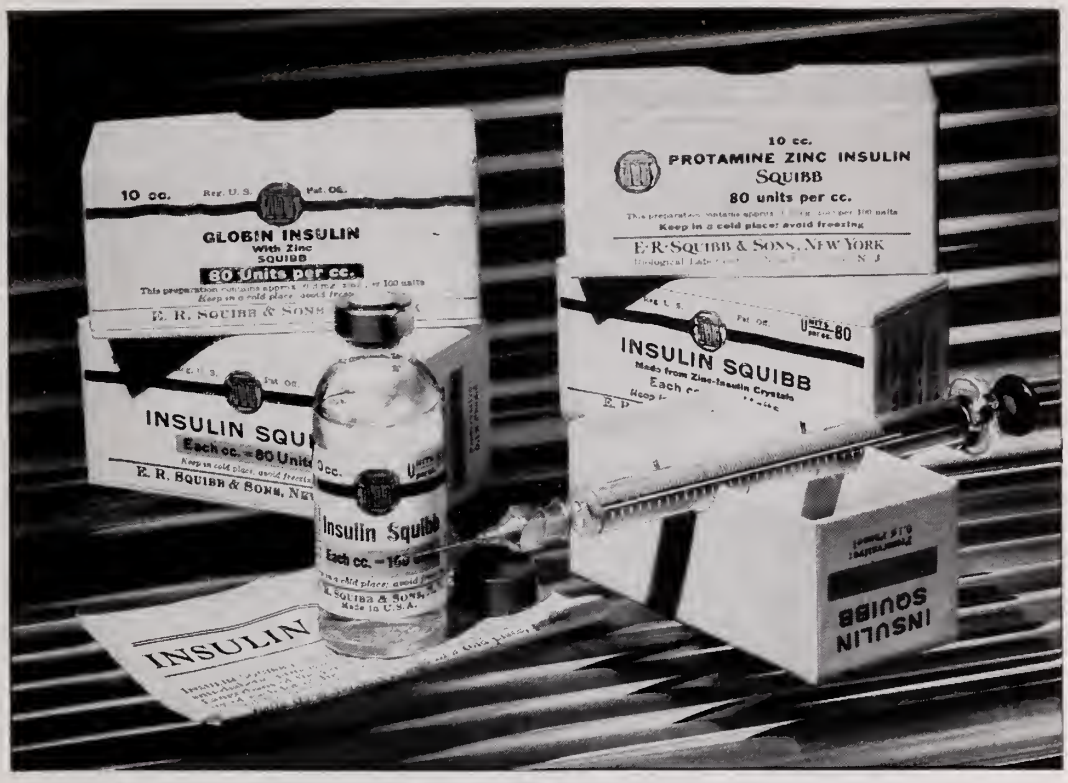


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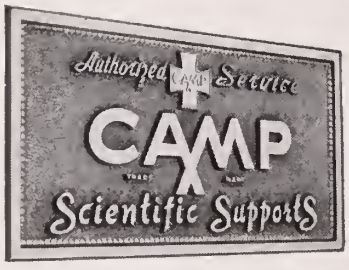


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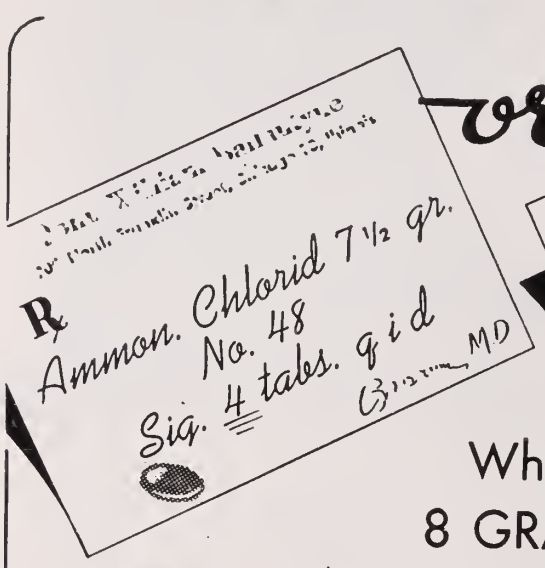
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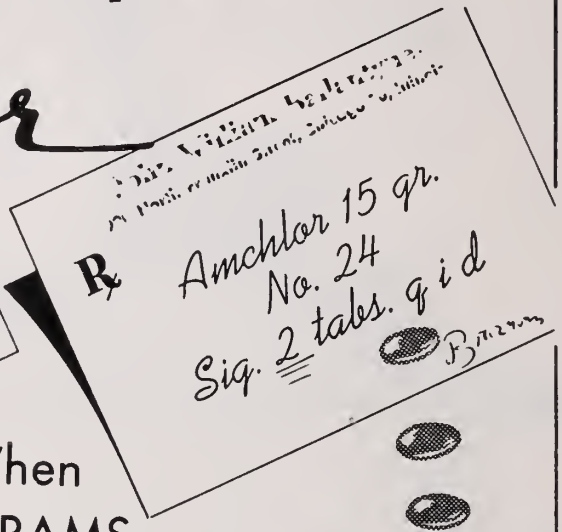
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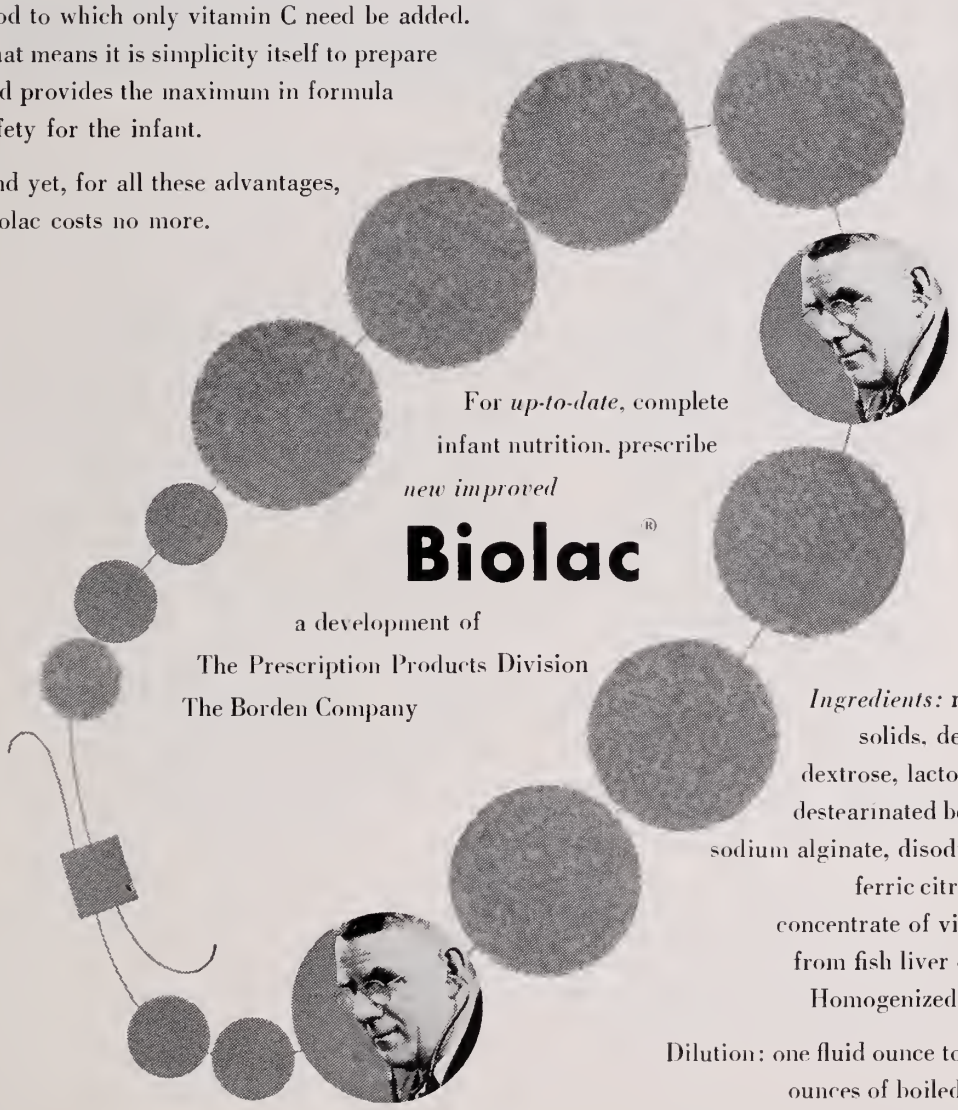
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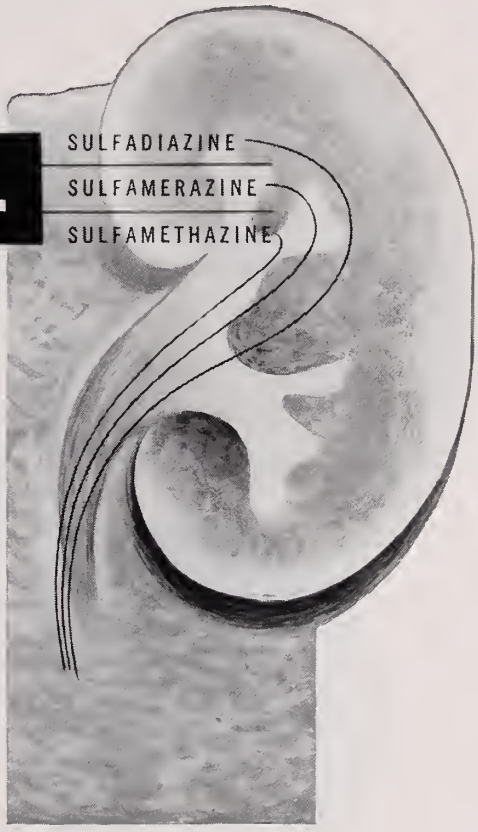
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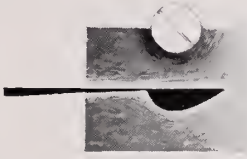
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXIII JANUARY, 1950 NO. 1

ENDOMETRIOSIS: A REPORT OF 400 CASES*

JOHN FALLON, M.D.; JAMES T. BROSNAN, M.D.;
JOHN J. MANNING, M.D.; WILLIAM G. MORAN, M.D.;
JOHN MEYERS, M.D.; M. ELIZABETH FLETCHER, M.D.

The Authors. *John Fallon, M.D., Surgeon, Fallon Clinic and St. Vincent Hospital; James T. Brosnan, M.D., Physician, Fallon Clinic and St. Vincent Hospital; John J. Manning, M.D., Surgeon, Fallon Clinic, and Assistant Surgeon, St. Vincent Hospital; William G. Moran, M.D., Pathologist, Fallon Clinic; John Meyers, M.D., Physician, Fallon Clinic and Assistant Physician, St. Vincent Hospital; M. Elizabeth Fletcher, M.D., Roentgenologist, Fallon Clinic.*

DR. FRANK PEMBERTON once said that "Endometriosis is where you look for it." Since we began to look seriously and to look for early lesions, there have been 240 cases of microscopically verified endometriosis and only 114 of acute appendicitis in the female portion of our practice. This practice, it should be explained, is that of a small group doing internal medicine, general surgery, roentgenology and pathology: except for the lack of obstetrics, a practice truly general. This incidence of endometriosis cannot be attributed to special referral: less than a score of our patients appear to have been referred as endometriosis suspects. We therefore believe that endometriosis is a wide-spread disease.

Endometriosis is wide-spread, too, in another sense of the word. It reaches into several specialties. Psychiatrists twice have consulted us for problems traced to endometriosis via marriages broken by dyspareunia and sterility. Five of our patients had dermatologic manifestations. The urologist meets endometriosis as a bladder tumor or ureteral obstruction, the obstetrician as a sterility problem, the general practitioner and internist as a common cause of abdominal pain or possibly the most frequent cause of severe dysmenorrhea. The general surgeon may encounter it whenever he opens a woman's abdomen. We have seen gastric, cholecystic and appendiceal as well as the common intestinal lesions.

*Presented at the 138th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 11, 1949.

There is extraordinary variation in the importance attached to the disease by various men. One asks: "What's a little endometriosis among friends?", another castrates every patient. Endometriosis is a growth, characterized by speed, spread, invasion, sometimes metastasis. Its natural course is toward severe pain, dyspareunia, sterility and obstruction of the urinary or intestinal tracts. Only a minority of cases, a minority of unknown size, follows that course into extremes before either treatment or the menopause reverse its direction. But until we can predict whether the given case will follow the majority or minority course, endometriosis should not be underestimated. Routine castration, on the other hand, is gross overestimation of the disease.

Pathology

What is endometriosis? Time is changing the word's meaning. Originally it meant a growth of endometrium anywhere except where it was supposed to be, lining the uterus. This included diffuse glandular permeation of the uterine muscle (adenomyosis) and fibroids which contained gland tissue (adenomyomata) as well as the endometriosis of chocolate cysts and blueberry spots which John Sampson put upon its clinical feet. Later, adenomyosis and adenomyoma were called "internal endometriosis", as being within the uterus, and the Sampsonian disease "external". Because there is no clinical similarity between the three diseases; because block-like masses of Sampsonian endometriosis, especially in the round ligament or rectovaginal septum, have been miscalled "adenomyomata" and because true adenomyomata may occur external to the uterus, it seems time to abandon the internal-external terminology and speak specifically of adenomyosis, adenomyoma and endometriosis, reserving the latter name for Sampson's disease. This paper reports 400 cases of endometriosis in that sense of the word.

continued on next page

Endometriosis and chocolate cyst are not synonymous. There is much to endometriosis before and beyond the chocolate cyst of the textbooks.

First of all there is the early, small chocolate cyst (Fig. 1) which we general surgeons miss because we take out appendices through right rectus incisions and explore the pelvis by palpation rather than inspection. To the hand, these little chocolate cysts feel like normal follicles. The diagnosis is for the eye, not the hand, to make and the gynecologist, who works with a median incision and with light enough to see the pelvis, makes it.

Then there are other lesions in addition to the chocolate cyst. These lesions are caused by spillage from chocolate cysts (this, it is fair to say, we know) and also (we believe) arise directly from whatever is the etiologic mechanism of the disease.

It is the destiny of the chocolate cyst to perforate: only once in our 400 cases has an ovarian chocolate cyst built up to a large size (10 cm.) without leaking. Pseudocysts, walled enclosures of tarry fluid between the ovary and peritoneum following previous perforation of a smaller chocolate cyst, may, however, grow large. When one of these or one of the larger ovarian cysts perforates, the perforation may be a sudden blow-out, with spread of the irritant tarry content over the lower half or all of the peritoneal cavity. This usually produces the syndrome of "menstrual appendicitis", that is, the signs of an abdominal emergency timed at or just before the period. Eight percent of our 400 people have had blow-outs and we have explored them for acute appendicitis, ectopic pregnancy or perforated ulcer as often as for the correct diagnosis. These are the folk in whom you see the lymphatics of the omentum, mesentery and appendices epiploicae so choked with black cyst content that you worry about the theoretic possibility of metastasis.

Blow-out, however, is the unusual method of perforation. Usually perforation is by seepage, monthly seepage, beginning after a lesion reaches the diameter of approximately 1 cm. Endometriosis appears to remain relatively dormant through the first part of the menstrual cycle then put on a spurt of growth for a few days before and during menstruation. This monthly increment of growth plus the irritant monthly seepage—something more added each month to the already existing total of disease—will, as you will see, furnish the principal key to clinical diagnosis.

What happens after the cyst content escapes? Irregular splashes of viscous brown material—"Brown spatter"—stick tenaciously to the peritoneum. Within a few days this brown spatter adheres so firmly that even a sponge cannot rub it off without leaving multiple bleeding points in the peritoneum. At about 6 weeks a thin covering layer of endothial-like cells may stretch from normal peritoneum to normal peritoneum across the spilled material, so that the lesion can be removed only by sharp incision, en bloc with peritoneum. In other words, the spilled material has begun to be encapsulated or, by another interpretation of the same phenomenon, to invade. We believe that viable endometrium spilled from a tube would act similarly, but there is not time to enter the fight over etiology.

Despite many attempts, we have failed to demonstrate endometrial glands and stroma in brown spatter. Microscopic confirmation of "Red roughening", the next lesion, has however been quite consistent. Indeed it may be easier to verify red roughening than a chocolate cyst. In the old chocolate cyst, hemorrhage and necrosis often destroy microscopic design.

Red roughening (Fig. 2) was seen in 9% of our series, almost always in conjunction with older and better known stages, either in the form of shaggy, fibrin-like fronds of soft tissue hanging from the peritoneum or as a rough, red placque on the peritoneum. Red roughening looks like granulation tissue to the eye and the microscope shows granulation-like tissue with occasional glands and stroma in its interstices.

From red roughening, we believe, the disease may progress in either of two ways; by forming an endometrioma or by forming a blueberry spot.

The blueberry spot (Figs. 2, 3), varying from a pin point to, infrequently, 5-6 mm. in diameter, is a cyst walled around by peritoneum and fibrosis. It may occur anywhere on or just under visceral or parietal peritoneum. This lesion has been known as long as the chocolate cyst. What may not be known about it is that it is not always blueberry. It may be black, tan or even colorless or white. Eight percent of our 400 patients had "white" endometriosis, in the form of discrete, colorless little cysts or in the form of a conglomerate tumor of such cysts or as simple white sclerosis, looking like ordinary scar tissue. Some of these colorless lesions mimic ordinary peritoneal inclusion cysts. We do not remember seeing any such amenorrheic endometriosis—if you will forgive the pun—which was not accompanied by ordinary, colored lesions. Queerly enough, these erratic forms of endometriosis usually are easy to verify microscopically.

What happens to the blueberry spot? If the surrounding fibrosis wins its struggle to contain the lesion and an adequate capsule is formed, the lesion arbitrarily is called quiescent. Whether we are right in using the word is doubtful. Somers Sturgis of Boston has suggested* that possibly these firmly encapsulated lesions, by trying to expand against their capsules, may cause more pain

*Personal communication

continued on page 18



FIGURE 1. *Photograph of Ovary (x 1).*

An early chocolate cyst, 4 mm. in diameter, illustrates the importance of visual exploration of the pelvis. Cysts less than 1 mm. in diameter can be identified — if one looks instead of feels.



FIGURE 2. *Photograph of Piece of Excised Pelvic Peritoneum (x ¾).*

This shows, below, a small "blueberry spot" and, above, "red roughening."

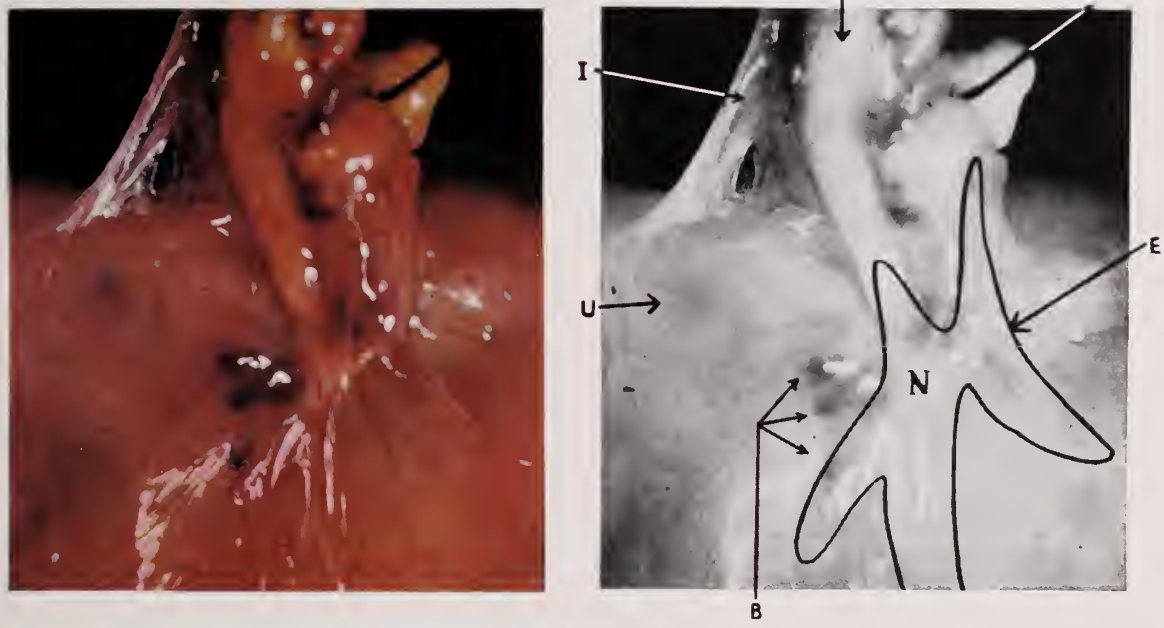


FIGURE 3. *Photograph of Both Inflammatory and Endometriotic Adhesions between an Appendix Epiploicum and the Uterus (x 2).*

U is the uterus, A on appendix epiploicum, and S a retracting suture. This illustrates certain differences in appearance and in nature between endometriosis and chronic pelvic inflammation. The inflammatory lesion (I) is thin, sheet-like, stretching. The adhesion of endometriosis (E) is strong, solid, contracting; note the typical stellate lines of puckering. "Blueberry spots" appear at B, and a nodular endometrioma at N.
(For permission to reprint these photographs the authors are indebted to the New England Journal of Medicine.)

than do less anatomically "quiescent-appearing" lesions. Also, we have seen spillage surrounding blueberry spots which were so firmly encapsulated that, lacking such suggestion of activity, we otherwise would have called them quiescent. For what it is worth, the proportion of our 400 patients whose lesions we called quiescent was 9%. This does not mean that 9% of endometriosis is quiescent: the surgeon sees quiescent lesions only when those who harbor them happen also to have other disease which brings them to operation. So we do not know what proportion of the population at large may have quiescent lesions. Nor do we know what proportion of quiescent lesions ultimately cease being quiescent. To confuse the issue further, even highly active endometriotic lesions may be silent, especially if they are confined to the ovary and do not involve peritoneum. More than once we have operated for blow-out of a chocolate cyst in a patient who, before the day of blow-out, never had a pelvic pain. Suppose such a patient had an innocuous fibroid, as such patients often have; suppose the operation had been done the day before, for the fibroid: then her dangerous endometriosis, by the unscientific rigidity of hospital terminology, would have been "incidental" to the modest fibroid. We hesitate longer at our 400th. case than we did at our 200th. to call a given lesion incidental or quiescent.

Is the blueberry spot a way-station along the course of the disease or only a terminal lesion? Many blueberry spots we have seen have been surrounded by peritoneal lesions suggesting old, recent or repeated spillage. We therefore believe it can be either.

The true terminal stage of the disease is the endometrioma and we believe this lesion may be reached either directly from a red roughening or through the mediation of a blueberry spot which spills its contents or grows through its capsule.

Figure 3 shows, side by side, chronic pelvic inflammatory disease and an endometrioma. Notice the difference between them. The inflammatory adhesion is a thin, weak, stretching structure: it is an old defense mechanism whose work is done; it is trying to disappear. On the other hand the endometrioma is active, invading tumor. There is a central, woodeny-hard placque of growth which microscopically shows endometrial glands and stroma surrounded by and interspersed with dense fibrosis. From the central mass radiate outward the stellate lines of contraction so typical of the gross appearance of endometrioma. Beneath these lines the microscope shows columns of advancing endometrium which have broken through the encapsulating fibrosis to invade neighboring tissues. We believe that the combination of this invasion, of the fibrous response summoned by invasion and of the ultimate contraction of fibrosis explain both the gross appearance (stellate lines) of the endometrioma and its more unpleasant consequences, the intestinal strictures and those blocks of growth which compress, without invading, the ureter.

The lesions of endometriosis may occur anywhere in the abdomen, occasionally outside the abdomen and even in the extremities. In our 400 patients, endometriosis in one stage or another was located in the gallbladder (3 patients); in the peritoneum of the right upper quadrant (2 patients); stomach (1 patient); inguinal canal (1 patient); labium majus (1 patient); appendix (3%); laparotomy scar (2%); cervix (1%); bladder (18% including 2 patients with serious involvement, none with penetration through mucosa); over or around ureter (6%); on small intestine (3%: 4 patients with stricture); large intestine (23%: 36 patients with partial to complete stricture); rectovaginal septum (27%).

Diagnosis

The location and extent of the lesions determine the kind of symptoms. Thus bilateral occlusion of the ureters will produce a different syndrome than sigmoidal obstruction and disease confined to an ovary may be utterly painless until it perforates. But wherever the lesion and whatever the stage, there is one common denominator; the addition, month after month, to the amount of disease present.

This, we believe, explains the cardinal symptom[1] of the disease: cumulative increase of some menstruation-linked phenomenon. This phenomenon usually turns out to be pelvic pain because most people with endometriosis have some of it somewhere in the pelvis: 91% of our patients had pelvic peritoneal endometriosis, 66% had ovarian.

To save words we may call this cardinal symptom "increasing dysmenorrhea" provided that two warnings are remembered. Firstly, "dysmenorrhea" is not necessarily "cramps". The pain of endometriosis can be cramp but it also can vary from a misery in the back to a sharp stab at McBurney's point. Secondly, remember that "increasing" dysmenorrhea and "acquired" dysmenorrhea are altogether different phenomena. The woman who did not have dysmenorrhea, and now does have it, by definition has "acquired" dysmenorrhea. She also has increasing dysmenorrhea: it has increased from none to some. On the other hand, the woman who had dysmenorrhea ever since the menarche, but whose dysmenorrhea now is increasing, does not have acquired dysmenorrhea but she does have increasing dysmenorrhea and she is just as likely to have endometriosis as her sister with the "acquired" symptom.

Common sense must be applied to this symptom of increasing dysmenorrhea. The history of one or

two periods a little more painful than their predecessors is not significant. The increase of endometriotic dysmenorrhea is constant and cumulative. Unfortunately, absence of the symptom does not exclude endometriosis. Although we consider it the cardinal symptom of the disease, we elicited it in only 202 of 400 patients. And "elicit" is the proper word. Patients do not volunteer this symptom. One must cross-question.

With only half the patients manifesting the cardinal symptom, one must look further for help in the diagnosis. Other symptoms unfortunately offer little help. Menorrhagia or metrorrhagia, ordinarily listed by text books as important symptoms, were present in less than a third of our patients and usually could be explained by concomitant disease. Dyspareunia is suspicious and increasing dyspareunia is at least as significant as increasing dysmenorrhea, but neither is often present. Rectal bleeding at menstruation, a favorite of the older texts, is practically a freak of nature: although 96 patients in this series had some degree of large bowel involvement, only once did an endometrioma project through the mucosa into the bowel lumen (it was at the rectosigmoid) and the other 95 lesions rode free in the outer layers of the gut, not even attached to the mucosa. Of course, we saw patients with rectal bleeding. But we thought it came from their piles—or their cancers. Bowel tumors which bleed are, until microscopically proven, not endometriosis but carcinomata.

Involvement of bowel, ureter or bladder may contribute to diagnosis by menstrual-linked urinary symptoms, constipation or rectal pain, especially if the latter is aggravated by jarring (defecation, coitus, riding). Cystoscopy may show a tumor which penetrates the vesical mucosa and so is available to biopsy: although penetration was not met in our patients, at least 14 cases have been reported and we know of several others. Proctoscopy should prove that a bowel lesion is extramucosal, although the overlying mucosa may be injected. Bowel lesions must be fairly advanced to appear in X-ray, but the demonstration of intact mucosa at a stricture or side-wall defect is most important. Multiple sigmoidal lesions or a hydroureter beginning just behind the uterine artery cross-over are highly suspicious.

In addition to a cardinal symptom, endometriosis has a pathognomonic sign: the hard, infiltrating nodule in the pelvis as felt by vaginal and rectal and, best of all, combined rectalvaginal examination. Once appreciated, the feel of this lesion is not likely to be confused with anything else except possibly metastatic peritoneal carcinoma. But we do not believe one should wait for palpable endometriosis before making the diagnosis. In this we disagree with some of the best men in the field. But only 27% of our cases had lesions large enough to feel which happened to occur within reach of the finger. So, had we waited for palpable nodules some three-quarters of our cases would have been missed.

Unfortunately endometriosis often occurs in people with other pelvic diseases, the symptoms of which may obscure its symptoms, and in childless women, whose neurotic complaints may lull one into the false security of assuming that their other symptoms, too, are functional. This misfortune may be turned to advantage if one looks upon other pelvic disease and childlessness as reminders of endometriosis.

The habit of remembering endometriosis in an especial group of susceptibles has been, next to the appreciation of increasing dysmenorrhea, our greatest aid in diagnosis. The disease mostly occurs in a sharply delimited fraction of the population: mature females who are not having children. By mature is meant physiologically mature, menstruating. More precisely, endometriosis occurs at any age, including youth[2], between 2-3 years after the menarche and the menopause. (We ourselves have seen no active endometriosis later than cessation of flow). Almost half of our 400 patients were childless and 90.2% had not had a child within five years of our making the diagnosis. This does not mean that women can not have endometriosis within five years of parturition: 10% of these women did (although, to be sure, most of this fraction consisted of women whose symptoms antedated the pregnancy or who had artificial endometriotic transplants into operative incisions). But it does mean that we should look for the disease in women who are not having children, no matter whether the childlessness be from indecision, inability or lack of opportunity.

One practical contribution to endometriosis, worth a dozen a priori arguments on etiology, has been Meig's advocacy of early marriage. Early childbearing might prevent endometriosis and at least would give women their children before endometriosis struck. It is not only the children but the women and their husbands for whom the point is important: the dysmenorrhea, dyspareunia and sterility which endometriosis causes are potent, if unromantic, home-wreckers. The prophylactic importance of early procreation, however, should not lead us into diagnostic error: long past pregnancies do not guarantee against present endometriosis. Fourteen of our patients had 5 or more children, stopped having children then, after 5 or more years, developed endometriosis.

A final aid to preoperative diagnosis is endoscopy either by peritoneoscope or culdoscope and, since the results of undetected endometriosis can be so

continued on next page

serious, we believe that one should be radical about endoscoping the doubtful case. Preoperative diagnosis still is imperfect but it is far from the impossibility that some writers imply. Our own rate has been raised from disgracefully near zero to 70% by *searching for increasing dysmenorrhea in women who were not having children and by peritoneoscoping on suspicion.*

Treatment

At several meetings during recent years we have shown exhibits on or including endometriosis. Now the exhibitor stands like a beggar beside his placard, and men from all over the country who know his subject come to pour their information into his cup. The reader of a paper may answer a few questions: the exhibitor can ask them all day long.

The gleanings of our cup show that the treatment of endometriosis throughout the country differs from any pattern you might expect from your reading. There is, in fact, no pattern. The most popular principles of treatment seem to be: 1. Routine castration: 2. Removal of large lesions, especially chocolate cysts, leaving peritoneal lesions untouched and saving ovarian fragments; 3. As #2, with hysterectomy but without oophorectomy: 4. Doing nothing so long as possible, then castrating: 5. Castrating by radiation, sometimes on symptomatic diagnosis alone; 6. Estrogenic, luteinizing or gonodotropic substances.

Obviously, large-scale, long-term follow-up studies based upon personal physical examination are needed.* For today's paper, we undertook such a study of one principle of treatment. We found that it cannot be finished until long after today, but it has progressed far enough to show disappointing results.

Our principle of treatment has been to remove or castrate: either to remove all endometriosis, however extensive and wherever located or, if this were mechanically impracticable, to do complete hysterectomy and bilateral salpingo-oophorectomy. In a few exceptions, partial (supracervical) hysterectomy with bilateral salpingo-oophorectomy or bilateral salpingo-oophorectomy alone were done, and a few older patients with recurrence or extensive, peritoneoscopically verified disease were castrated by radiation with no attempt at excision of the growth. A few young women with extensive lesions were considered to be exceptions and were not castrated even though we were unable to excise every last morsel of the disease. These are the only patients in whom partial removal has been tried. We have not tried removing part of the ovarian tissue nor leaving in the ovaries and removing uterus alone.

*Bacon's[5] notable study has appeared since this paper was read.

Our principle of remove or castrate has let us into some heavy surgery; intestinal resections, plastic and urological operations and tedious dissections of the pelvis followed by an appreciable morbidity and one death (2 other patients with incidental untreated endometriosis died from their principle disease, carcinoma). Despite this our castration rate is too high (52%) and our recurrence rate, so far in the follow-up, is considerable.

In brief, our follow-up will show that some better principle of treatment should be sought. Possibly other principles may prove even less satisfactory in the long run and we may return to the idea of remove-or-castrate. But for the time being we are continuing to remove all lesions which are mechanically removable and, for these lesions which, at peritoneoscopy or exploration, are considered mechanically unremovable we are trying either stilbestrol in doses smaller than Karnaky's[3] or testosterone[4]. Because the results of hormone treatment still are unproven and because the doses of testosterone which must be used are large enough to risk masculination and those of stilbestrol enough to risk, at least in theory, carcinogenesis, we believe that neither agent should be used without operative or peritoneoscopic confirmation of the diagnosis. And pending further end-result study, we ourselves do not propose to use either of them as a substitute for excision of the disease but only as a substitute for castration, when the disease is mechanically unresectable.

On the other hand it seems that, for the present, even the bare possibility of effective chemical therapy removes most of whatever justification there was in the past for occasional castration.

Finally, even though the follow-up study is unfinished, it has uncovered one bit of absolute evidence. The finding of 52 pregnancies following non-castrating operations for endometriosis proves that the principle of routine castration never was justified.

Summary

In women, endometriosis is more frequent than appendicitis and its manifestations extend into several specialties of medicine. The cardinal symptom is cumulative increase of some menstruation-linked phenomenon, usually pelvic pain; the pathognomonic sign is the characteristic "feel" of an endometrioma. This is best appreciated by simultaneous rectalvaginal examination. Cardinal symptom and pathognomonic sign often are lacking and a most helpful trick of diagnosis is expecting the disease in women who are not having children. Contrary to general belief, it does occur in youth.

Peritoneoscopy (or culdoscopy) is indicated where doubt exists. But exploration of the pelvis

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METASTATIC CALCIFICATION AND RENAL FAILURE FOLLOWING ERTRON THERAPY IN AN AGED ARTHRITIC*

HARRY HECKER, M.D.

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BY CHANCE, it was noted that patients treated with Vitamin D for allergic conditions experienced alleviation of arthritis. Soon there was a flood of medical tracts which, over the years, thoroughly confused the practitioner because of their divergent reports.[1] But, though the efficacy of Vitamin D therapy was in doubt, being variable and unpredictable, it soon became certain that toxic effects occurred[2]—some lethal and bizarre. The literature discloses that, to date, six patients have been autopsied following hypervitaminosis D. Metastatic calcification was noted in all.[3]

The amounts of Vitamin D deemed necessary in arthritis are far beyond the non-toxic doses necessary to prevent rickets. The preparations which have proven toxic[4], in the order of their potency, are—

1. Ultra violet irradiated ergosterol.
2. Electrically activated vaporized ergosterol (Ertron)
3. Simple fortified cod liver oil.

20,000 international units per kg. body weight per day, is usually considered as the minimum toxic dose for human beings. But toxic effects have been reported in one adult with 1,000 units per kg. of body weight[5].

* * * * *

The author wishes to thank Dr. J. Greenstein, chief of medicine, The Memorial Hospital, and Dr. E. Benjamin, chief roentgenologist, The Memorial Hospital, for their help in preparing this report.

It is thought that Vitamin D first injures the cell and that this is followed by the deposition of calcium. Abnormal tissue calcification can occur with total blood calcium values that are not elevated. A rapidly fluctuating level of serum calcium is more likely to produce pathological calcification than a persistently elevated one. Calcium is deposited throughout the soft tissues of the body and at the following major sites—

Arteries—Inner layer of media
Kidneys—Tubular epithelium, basement membrane and interstitial tissue, lumen collecting tubles
Lungs—In lining of pulmonary alveoli and bronchi
Stomach—Muscularis, basal portion of gastric mucosa cells
Heart—Coronaries
Brain—In and beneath dura, falx, tentorium

Clinical History

The following case is illustrative of the widespread soft tissue calcification and is of special interest because the patient is apparently the oldest so far reported:

The patient, a 70-year-old, tiny, emaciated, gray-haired woman, was admitted to the Memorial Hospital on November 16, 1948 with a diagnosis of pneumonitis. She had a dry cough and had been vomiting green material for 4 days. She had been well until 4 years previously when she developed arthritis of the upper extremities and ankles with resultant deformities of the hands. For this condition she was treated with Ertron (50,000 units per capsule). She stated that she took 12 capsules daily, "For many months" and then 6 daily, "For a long time—over a year." Painless, progressive swellings appeared at the sterno-clavicular joints. (Fig. 1)

continued on next page



FIGURE 1

*Presented at the John F. Kenney Annual Clinic of the Memorial Hospital Internes' Alumni Association, at Pawtucket, R. I., November 2, 1949

These were described as being "Firm but somewhat fluctuant."

X-rays taken on admission showed an area of haziness and slight density over the mid portion of the right lung. Also widespread areas of calcification were seen in various soft tissues of the body. (Figs. 2, 3, 4). Patient received penicillin therapy, and she ran an occasional mild, irregular temperature ranging to 103.6°F. on two occasions. Thirteen days after admission, x-rays disclosed complete resolution of the pneumonic process. She was discharged home on December 5, 1948.

The following is a table summarizing the laboratory data with comparative figures of a case[2] reported by Hyde, L., Hyde, B., in the *Annals of Internal Medicine*, 1947.

	H.#96726 70 yr. old female	Case Reported by Hyde, L.–Hyde, B. 59 yr. old male
Blood		
B.U.N. (mg./100 c.c.)	40	43
	37	
	32	
Creatin (mg./100 c.c.)	3	2.4
	2.6	
	2	
Uric Acid (mg./100 c.c.)	3.65	
Cholesterol (mg./100 c.c.)	147 (Esters 69%)	
	97.6 (Esters 58%)	
Chlorides (mg./100 c.c.)	420	
	520	
Serum		
Calcium (mg./100 c.c.)	10.6	9.3
	10	
Alk. Phos. (King Armstrong Units)	2.8	6.5
	5.2	
	8.4	
Alb. (gms./100 c.c.)	2.7	3.5
Globin (gms./100 c.c.)	3.2	3.
Blood Counts		
Hgb. (Sahli) (gms./100 c.c.)	9.7	9.1
R.B.C. (per cu. mm.)	3,230,000	2.8
Urine		
Alb.	++	+
Mic.	W.B.C. ++ to + R.B.C. – – to +	Occ.W.B.C.
Conc. and Dil.	1.002 to 1.007	1.011
P.S.P.	(1) Spec. #1 5% Spec. #2 Less 5%	45%
	(2) Spec. #1 Less 5% Spec. #2 13%	

When one considers the frequency of arthritic complaints in the aged, the pages of Geriatrics are strangely free of reports of Vitamin D poisoning. The answer to this paradox may lie in either the inheritant wisdom of the aged or the fact that many complaints have been taken as timed honored attributes of age. None the less, following are listed factors which make them more susceptible to Vitamin D poisoning:

1. Immobilization[6] — Bed-ridden patients, through atrophy of disuse, as emphasized by



FIGURE 2: The kidneys are easily delineated by areas of calcification in its substance.



FIGURE 3: Large areas of soft tissue calcification about the shoulder, in the axilla and on the back.



FIGURE 4: The deformities of hands were due to calcified masses not arthritis.

Albright, may produce hypercalcemia with resultant renal damage.

2. Diet—Exodontia, economics and lack of robust appetite revert the aged to a diet in which the nucleus is milk. It has been shown that the absolute as well as the relative amounts of calcium and phosphorus in the diet influence the toxicity of Vitamin D[7].
3. Constipation—Toxicity more likely to occur in patients with G.I. disfunction.
4. Greater incidence of kidney pathology—Impaired kidney function should be considered contraindication to treatment.
5. Wear and tear of time—Calcification may be facilitated by local tissue injury already present.

Conclusions

It is likely, for the reasons just outlined, that the aged patient should not be treated with potent Vitamin D. If it is used in younger patients, it is essential to anticipate any possible toxic effects by routinely studying the calcium metabolism and the functional state of the kidneys.

BIBLIOGRAPHY

[1] Danowski, T. X., Winkler, A. W. and Peters, J. W. "Tissue Calcification and Renal Failure Produced by Massive Dose of Vitamin D. Therapy of Arthritis," Annals of Internal Medicine, 1945, I, 22-29.

[2] Hyde, L., Hyde, B., "Toxicity of Large Doses of Vitamin D (Ertron)," Annals of Internal Medicine, 1947, 4, 617-627.

[3] Donegan, C. K., Messer, A. L., Orgain, E. S., "Vitamin D Intoxication Due to Ertron; Report of Two Cases," Annals of Internal Medicine, 1949, XXXIV, 429-435.

[4] Bauer, J. M., Freyberg, R. H., "Vitamin D Intoxication with Metastatic Calcification," J.A.M.A., 130, 1208-1215, 1946.

[5] McChesney, E. W., and Messer, F., "The Metabolism of Calcium and Phosphorus as Influenced by Various Activated Sterols," American Journal Physiology, February, 1942, 135-577.

[6] Albright, Fuller, Barnett, D. H., Cope, Oliver and Paran, Wm., "Acute Atrophy of Bone (Osteoporosis) Simulating Hyperparathyroidism."

[7] Freeman, S., Rhoads, P. S., Yeager, L. B., "Toxic Manifestations Associated with Prolonged Ertron Ingestion." J.A.M.A., January 26, 1946, 130, 4, 197.

ENDOMETRIOSIS: A REPORT OF 400 CASES

concluded from page 20

by palpation alone, without vision, will fail to demonstrate "brown spatter", "red roughening", small chocolate cysts and colorless endometriosis.

There still is little positive knowledge about treatment and more follow-up studies are needed. The unfinished follow-up of our own cases, treated by either removal of all disease or by castration, shows a high castration rate (52%) and a recurrence rate which, even after wide resection, is high enough to justify a search for better methods. But 52 postoperative pregnancies are conclusive proof that routine castration is absolutely unjustified.

REFERENCES

[1] Fallon, J., Brosnan, J.T. and Moran, W.G.: Endometriosis: two hundred cases considered from the viewpoint of the practitioner. New England J. Med., 235: 669-673, (November 7) 1946.

[2] Fallon, J.: Endometriosis in youth. J. Am. Med. Ass., 131: 1405-1406, (August 24) 1946.

[3] Karnaky, K. J.: The use of des stilbestrol for endometriosis; preliminary report. Southern Med. J., 41: 1109-1111, (Dec.) 1948.

[4] Hirst, J. C.: Conservative treatment and therapeutic test for endometriosis by androgens. Am. J. Obst. & Gyn., 53: 483-487, (Mar.) 1947.

[5] Bacon, W. B.: Results in 138 cases of endometriosis treated by conservative surgery. Am. J. Obst. & Gyn., 57: 953-958, (May) 1949.

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AUREOMYCIN IN THE TREATMENT OF PEMPHIGUS

Report of a Case

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THE CAUSE of pemphigus is unknown. Its characteristics are the insidious or sudden onset of bullous or vesicobullous lesions on apparently normal skin and mucous membranes. Remissions may occur, though relapses and recurrences are the rule. Constitutional symptoms eventually resulting in death are usually the course of the disease. Three types have been described: Pemphigus vulgaris, foliaceus and vegetans.

Treatment has been mostly supportive and practically unsuccessful. Philips[1] recently treated a case of acute pemphigus vulgaris with aureomycin. The patient died, but apparently the remissions in the bullous skin manifestations before death may be attributable to the use of aureomycin. Sutton and Sutton[2] review the various therapies which have been used in pemphigus. Arsenic, iron cacodylate, liver, coagulen, sodium suramin (germanin), moccasin snake venom—(1:3000 solution), mercurochrome, methylene blue, gentian violet. Mercury chloride (1:5000) in isotonic saline and potassium permanganate baths (1:2000) have been helpful.

Also, fractional x-ray therapy has been used; dihydrotachysterol to increase blood calcium, vitamin D—(50,000-400,000 units daily) and riboflavin. According to many authors, the mortality is close to 95 percent. The average age of onset is in the 5th and 6th decades of life.

Report of a case:

On March 24, 1949 a 76-year-old white, male, American, a salesman of soft drink beverages, was admitted to the dermatological service of the Rhode Island Hospital with a bullous eruption involving the entire body surface. His skin was clear until six months previously when he first noticed small, scaly, non-bullous lesions on each inner thigh. These were only slightly pruritic. One month later the lesions became crusted and oozed following disappearance of the crusts. The patient had always been in good health, and particularly never suffered from any disease of the skin. The complaint began two weeks previous to admission, when the patient noticed the sudden onset of bullae over the trunk and extremities. Apparently the new lesions were grossly different from the small scaly lesions of six months previously.

It is noteworthy that the patient's arms and ankles were swollen for the two weeks prior to admission. There were systemic symptoms represented by chills and fever; no previous surgery, serious illnesses, unusual contacts, exposures or dietary indiscretions. He suffered from hay fever, but denied other diseases. Family history was irrelevant.

Physical Examination:

He was a well-developed and nourished, cooperative, elderly, white male, not acutely ill; blood pressure 130/75, temperature 97 degrees F., respirations 20/minute, pulse 70/minute. Over both legs, arms, chest and abdomen there was a dermatitis consisting of macules, vesicles and bullae, many crusts and excoriated lesions. There were many denuded weeping epithelial areas. Nikolski's sign was present. No mucous membrane lesions were found. The rest of the examination was normal except for a slightly enlarged heart; the liver was enlarged three centimeters below the costal margin, non-tender. A bilateral inguinal hernia and two plus ankle edema were present. The patient was not in cardiac failure. His edema cleared on bed rest. The diagnosis of pemphigus vulgaris seemed clinically warranted.

Because of some apparent success obtained in other cases, the patient was given fractional x-ray irradiation to the liver and spleen. He received a total dose of 306 roentgen units over a period of six days. No effect was demonstrable. Because of some appearance of the lesions suggesting dermatitis herpetiformis, he received three grams of sulfapyridine daily for five days. At the same time he was given 0.25 gram acetarsone for one day. The results were completely negative. Locally as suggested by N. P. Anderson of Los Angeles, a paraffin spray was applied to the body three times a day for eleven days. (Composition: paraffin wax, petrolatum, olive oil, sulfanilamide, menthol, camphor, oil eucalyptus). This moderately improved the situation. Other local medication consisted of

Lassar's paste with menthol and phenol. Two percent gentian violet in water was injected into the bullae and applied to the oozing areas. The patient also had potassium permanganate baths (1:4000) daily for fifteen minutes. He received a high protein pureed (was edentulous) diet which included double portions of chopped meat, proteinum eggnog four times a day, milk and fruit juices as tolerated. He received three multivitamin (Abdol with C) tablets and 50,000 units of vitamin D daily.

Under the described regime the patient did not do well at all. Diet was taken poorly. Periods of languor were alternated with spells of hallucinations and tremors. He was definitely disoriented and quickly becoming a major nursing problem. Many flaccid bullae enveloped the upper and lower extremities, chest and abdomen. The face, back and mucous membranes have never been involved.

On the assumption that the cause of pemphigus may be a virus, aureomycin has been used in many cases throughout the country. Successes as well as failures were reported. On April 4, 1949 administration of aureomycin was begun. He received one gram by mouth every six hours for twenty-four hours, followed by one-half gram every six hours for two days. Thereafter dosage was reduced to two hundred and fifty milligrams every six hours for seven days more. Finally he received two hundred and fifty milligrams every three hours for the next succeeding six days.

The first four days under this therapy were somewhat encouraging. The patient seemed stronger, more alert, and ate his food. On the 7th day a few bullae were still forming though less bullae appeared on the body as a whole than before commencement of aureomycin therapy. April 17, 1949, following the administration of sixteen grams of aureomycin by mouth over a period of thirteen days, the bullae had completely disappeared. Treatment was continued through April 20, when the continued excellent condition of the patient warranted a rest period. He was now rational, alert, and slept well. Appetite had returned and he took routine supportive therapy without complaint.

Six days following cessation of aureomycin therapy many new bullae were developing on the shoulders, lower abdomen, lower legs and ankles. Aureomycin was again given on April 22, 1949. Dosage this time totaled two grams daily given as two hundred and fifty milligrams every three hours by mouth. Within one week the patient was again free from bullae. Therapy was continued for sixteen days, when, with the continued marked improvement, aureomycin was discontinued for the second time on May 12, 1949.

continued on next page



Figure 1. Shows prompt clearing of bullous manifestations after first week of aureomycin. With exception of a few blebs on the ankle, the body is entirely clear at the present date, November 1, 1949, after 231 days from the onset and 250 grams of aureomycin. (Photo by G. Mancini).

Because of the reappearance of the lesions two days following cessation of treatment for the second time, aureomycin was administered for the third time on May 16, 1949. This was continued for two weeks, two hundred and fifty milligrams by mouth every three hours. The patient was free from lesions. Aureomycin was discontinued on May 30. June 1, a new crop of bullae appeared.

Because of the only temporary remission obtained with aureomycin, chloromycetin was administered on June 3, two hundred and fifty milligrams every three hours by mouth daily for two weeks. The patient had no remission this time. Bullae continued to develop on the trunk and extremities. Towards the latter part of the second week he commenced to go down rapidly. Oral temperature rose to 102 degrees F. No other source of active infection was found on physical examination. Lungs were clear to percussion and auscultation. He refused food and his hallucinatory depressions returned. Chloromycetin was discontinued on June 12, ten days following the initial dose and after a total dose of eighteen grams.

Administration of aureomycin was resumed. The patient did well. On June 22, aureomycin was reduced to a maintenance level of two hundred and fifty milligrams every six hours, exactly half of the effective dosage previously determined as satisfactory. Some bullae had persisted on the dorsum of both feet when the minimum dosage was initially prescribed. On this regime spontaeous vesicles re-appeared more slowly this time on the upper and lower extremities. After one week the eruptions had definitely returned, though less severely. The trunk was surprisingly free from new lesions. The apparently effective minimum dosage of aureomycin, two hundred and fifty milligrams, every three hours was administered again on June 29.

Laboratory Findings:

Red blood cells ranged from the low value of 3.3 million/cm3 with 10.0 grams of hemoglobin to 4.8 million/cm3 with 12.0 grams of hemoglobin when discharged. White blood cells ranged from 10,500 to 23,100/cm3. The differential smear repeatedly showed a marked eosinophilia (13 to 27 percent) with normal mature polymorphonuclears. Urinalyses were normal; blood sedimentation rate, 9mm/hr.; cholesterol, 168 mgm. percent; prothrombin activity, 75 per cent of normal; blood sodium chloride, 473 to 495 mgm. percent; total proteins averaged 5.0 grams; calcium, 7.9 mgms; phophorus, 4.2 mgms.; glucose, 90 mgms. The phytopharmacological tests (Macht-Pels 74; Macht-Ostro negative) were of no diagnostic help.

Dr. Melvin Burnett, resident in pathology, studied the sternal bone marrow, and reported as follows: "Several sections showed a preponderance of fat globules varing in size under oil immersion power. Here the cellularity is markedly decreased to almost absent. The fatty material is seen in all preparations, though less so in several. A noticeable decrease in erythropoiesis with an apparent shift to the left is observed. Erythropoiesis is normoblastic in nature with a significant increase in numbers of eosinophilic myelocytes and eosinophils. Granulopoiesis of the neutrophilic series is not judged to be abnormal. Megakaryocytes are present in sufficient quantity. Without the advantages of a bone marrow biopsy for complete architectural detail, it still is possible to state that there is a hypoplasia of the bone marrow cellular elements with specifically a depression of erythropoiesis. The significance of the increased eosinophilic myelocytes is not presently known."

The patient was discharged to a private convalescent home under special nursing supervision



Figure 2. Shows prompt recurrence of bullous manifestations after discontinuance of aureomycin. (Photo by G. Mancini).

following ninety-eight days of hospitalization. On this date he was in good health, enjoyed his food, and engaged in active, well oriented conversation. He was up and about the ward. The bullous eruptions with large denuded weeping areas and crusted areas seen on admission were no longer present. A few small vesicles gradually subsiding on the dorsum of the feet remained.

Nausea, vomiting and diarrhea have frequently been associated with aureomycin therapy. None of these symptoms were seen in our patient.

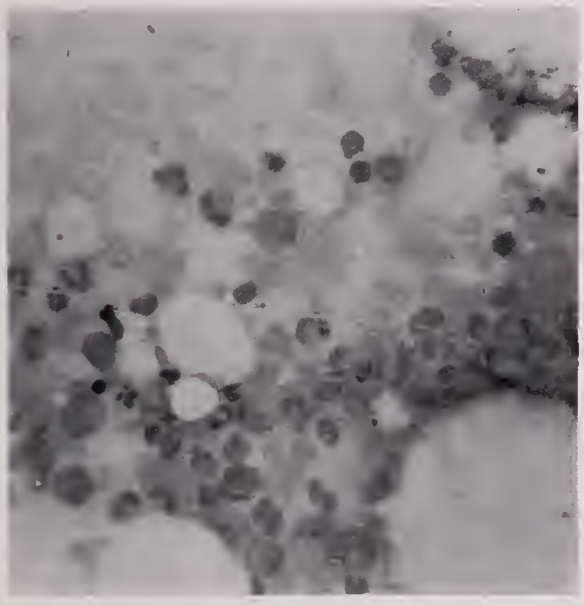


Figure 3. Cellular area of the bone marrow in which an occasional erythroblast is noted. Many of the segmented cells are eosinophils. X-240) (Photo by G. Mancini).



Figure 4. Smear of the bone marrow principally composed of fat globules. (X-60) (Photo by G. Mancini).

The patient was seen on November 1, 1949, two hundred and thirty-one days after the onset of the disease. He was still taking eight, two hundred and fifty milligram capsules of aureomycin daily. The total dose is now more than two hundred and fifty grams. He is free from lesions with the exception of a few blebs on the ankles and dorsum of the hands which appear spontaneously periodically, and regress without additional treatment.

Summary and Conclusions

Aureomycin in daily doses of two grams from April 4, to April 20, over a period of sixteen days, proved effective in practically clinically clearing a case of pemphigus vulgaris. Three times aureomycin was discontinued and the bullae promptly recurred. On a maintenance dose of eight, two-hundred and fifty milligram capsules daily, the patient on November 1, two hundred and thirty-one days after the onset of the disease is practically free from bullous lesions and in very good general condition. The total dose of aureomycin administered to date, November 1, 1949, is more than two hundred and fifty grams.

Chloromycetin has been used after a recurrence, but proved ineffective.

References

[1] Philip, A. J., Acute pemphigus treated with aureomycin, The Urologic and Cutaneous Review, 53:417-1949.
[2] Sutton and Sutton, Handbook of Diseases of the Skin, C. V. Mosby, St. Louis, 1949.
[3] Grace, A. W., Pemphigus vulgaris: a study of the blood picture, Arch. Derm. & Syph., 55:772, 1947.



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HERPES ZOSTER OTICUS

*Report Of A Case**

CHARLES A. McDONALD, M.D. *and* WILLIAM J. O'CONNELL, M.D.

The Authors, *Charles A. McDonald, M.D., Neurologist, St. Joseph's Hospital; William J. O'Connell, M.D., Assistant Physician, Outpatient Department, Department of Medicine, Rhode Island Hospital.*

HEREWITH is presented a case of Herpes Zoster Oticus. It is interesting to note the parallelism it makes with a case reported nearly twenty years ago by one of us (C. A. M.) which is included with this report.

W. S. M., aged 59, was examined on September 28, 1949. His past history did not reveal any major medical or surgical illnesses. On September 27, 1949 he noted dull aching on the right side of his head, accentuated by sharp twinges of pain in the skin and scalp above and around his right ear. On September 28, soreness developed about the right ear and considerable swelling soon appeared in this area. The ear drum was normal and the external canal not unusual. During the next two days the swelling about the right ear subsided. In this same period, however, the patient developed much lightheadedness. When lightheadedness was marked, nausea was present. Beginning September 29, 1949 an eruption appeared in the external canal and about the right ear. Hearing became markedly impaired. By September 30, 1949 definite vertigo was present which persisted but varied greatly in intensity for about two weeks. On September 30, 1949 the patient noted a metallic taste in the right side of his mouth and dryness of the right nostril. On October 1, 1949 the right eye became sore and painful; the right side of his nose felt numb and there was a marked weakness of the right side of his face with an inability to use the whole right side or to wrinkle his forehead.

On physical examination (September 29, 1949) there was no abnormality found in the nervous system excepting the condition of the ear and the facial nerve. There was a right facial paralysis involving all branches of the nerve. The ear was definitely erythematous and showed numerous vesicles. The external canal was closed with swelling and a creamy exudate. Several discrete clusters of vesicles were present on the right side of the soft palate and the right side of the tongue. Taste on the right side of the tongue was grossly disturbed.

COURSE—One week later the patient was improved. Nausea was no longer present, vertigo, although present, was very much less and taste had improved. The herpetic lesions in the aural cavity had nearly disappeared and those about the ear had undergone distinct involutional changes. The facial paralysis showed beginning recovery about the lips and naso-labial folds. The eye could be closed weakly. Hearing was slightly improved. Seven weeks later vertigo had entirely disappeared and hearing had nearly normalized. The herpetic lesions had completely disappeared and the external auditory canal was normal in appearance. Taste had returned fully and the tongue and palate were not remarkable. The facial paralysis had improved 50%.

* * *

Following is a case reported by Charles A. McDonald, M.D., and E. W. Taylor, M.D., at the Annual Meeting of the American Neurological Association, Atlantic City, N. J., June 11, 1930 and recorded in Vol. 25, pp. 601 in the Archives of Neurology and Psychiatry.

The patient, aged 36, the mother of one child, one having died in infancy, was examined in consultation with Dr. William H. Robey on December 20, 1929. Beyond the fact that she had had her tonsils removed fifteen years before, there was nothing of significance in the previous history. On December 20, she had a slight sore throat that did not demand medical attention. On December 17, she called a physician because of a feeling of soreness about the left ear, which was much swollen. There was also a palpable gland at the angle of the jaw. The ear drum was normal, and there was obviously no disturbance of the middle ear. The condition improved somewhat for a time. However, the patient had marked pain in the mastoid region. She stated that the left side of her upper lip felt as if procaine hydrochloride had been injected. She showed slight improvement until December 18, when facial paralysis developed, involving all branches of the nerve, but more particularly the

*Presented at the Eye-Nerve Clinic, Rhode Island Hospital, October 16, 1949.

lower ones. She had varied pain—aching, steady, sharp and intermittent—about the ear. At the outset this pain was rather inconstant. For several days before the herpetic eruption appeared, the patient suffered much from vertigo. She felt as if she were going to fall forward, and as if the automobile in which she was riding was going very fast. She had a similar experience when walking. The vertigo disappeared at the end of three or four weeks. She continued to have some tinnitus until January 1, 1930, about two weeks after the onset. The tinnitus was improved by blowing out the eustachian tube, and when examined on March 19 it had entirely disappeared. She continued to have some slight headache, but with this exception she was entirely well. There was no evidence of any herpetic eruption or of scars. Sensation was everywhere normal.

During the physical examination (December 20) no abnormality was found in the reflexes, pupils or the nervous system in general, except for the condition of the ear and the facial nerve. There was a pronounced facial paralysis on the left side with obvious involvement of all branches of the nerve, although the eye could be closed weakly. The pronounced swelling of the ear noted earlier had disappeared, but the auricle was markedly reddened and at various points showed some vesicles of a distinctly herpetic character. The external auditory canal was practically closed through swelling of its walls. Taste was definitely affected on the left side of the tongue.

COURSE—When the patient was examined again about a month later, there was decided improvement. The face had practically recovered its normal motility, with slight persistent weakness in the closing of the lids. The lower branches of the facial nerve had practically recovered, but the patient still noticed a small area of reduced sensation over the left side of the upper lip. The vertigo of which she had formerly complained had disappeared. There were no signs of herpes left, excepting a slight scar in the internal meatus. The Rinne test was positive. The sense of taste had returned. She was able to whistle imperfectly.

COMMENT—Of the virus infections of the central nervous system one must consider Herpes Zoster. This is particularly true of herpes of the cranial nerves. Whereas some investigators have been unable to demonstrate pathological changes in the cranial nerve ganglia at post mortem examination of patients with herpes zoster other workers have been able to recognize definite clinical patterns from inflammatory involvement of cranial nerve ganglia. It was by the zonal method of distribution of herpetic lesions due to inflammation of the geniculate ganglion of the facial nerve that J. Ramsay Hunt first demonstrated a sensory component of the facial nerve. Both cases here recorded had herpetic lesions localized in the zone attributed by J. Ramsay Hunt to the sensory portion of the seventh nerve, originating in the geniculate ganglion. The facial paralyses were undoubtedly due to the proximity of the motor and sensory branches of the seventh cranial nerve. Vertigo in both cases is presumably due to involvement of the vestibular portion of the auditory nerve. Diminution of hearing and tinnitus in these cases further associates the auditory apparatus. Bell's Palsy (Facial Paralysis) per se is unaccompanied by herpes. Facial Paralysis, acoustic nerve involvement and herpes together in the distribution in these cases reported must therefore originate in the same anatomic area, presumably the Geniculate Ganglion and thus the Geniculate Syndrome or Herpes Zoster Oticus.

Bibliography

Denny-Brown, D., Adams, R. D., Fitzgerald, P. J.—*Pathological Features of Herpes Zoster*—Arch. Neurol. and Psy. 51:216:1944
Gear, James—*Virus Diseases of the Central Nervous System*—Jr. of Neurol., Neurosurg., and Psy. 12:66:1949
Hunt, J. Ramsay—*On Herpetic Inflammation of the Geniculate Ganglion: A New Syndrome and its Complications*—Jr. Nerv. and Ment. Diseases 34:73:1907
McDonald, C. A. and Taylor, E. W.—*Herpes Zoster Oticus*—Arch. of Neurol. and Psy. 25:601:1931
Mills, C. K.—*The Sensory Functions Attributed to the Seventh Nerve*—Jr. Nerv. and Ment. Diseases 37:273:1910
Whitty, C. W. M. and Cooke, A. M.—*Unusual Complications of Herpes Zoster*—Jr. of Neurol., Neurosurg., and Psy. 12:152:1949

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AMA DUES

THE recent decision of the House of Delegates at the interim session of the American Medical Association to assess members of the Association $25.00 annual dues marks a change in a century old tradition. Members of county and state medical societies for over the past 100 years have automatically been members of the AMA without any financial obligation to the parent body.

The sweeping changes in our American way of life has engulfed the medical profession in this rush. No longer will the income from the Journal of the American Medical Association and other publications suffice to support the manifold activities of the Association with its many bureaus and councils, in addition to the added business of maintaining an economic eye with which it can closely scrutinize the social trends that are directed against the very foundations of our medical care system.

If one thinks briefly of the extended activities over and beyond the purely scientific aspects of medicine that have now become the proper objectives of the AMA, it is not difficult to realize why every physician will now pay dues at the (1) county level; (2) state level; (3) national level. Not only will these funds be used to continue the campaign against compulsory health insurance, but they will in part be used to support and continue such other activities as the Councils on Physical Medicine and Rehabilitation, Medical Service, Industrial Health, Pharmacy and Chemistry, as well as the Bureaus of Legal Medicine and Legislation, Medical Economic Research, Health Education, and Exhibits. Up to this year, these services were maintained without cost to members of the AMA. Now these functions of the AMA, as well as those in the many other fields in which it operates, have become the personal responsibility of each physician.

No amount of emphasis can project this responsibility to our doctors. Never before has the doctor as an individual been made to realize that he is a member of organized medicine from his county society through the state society to the American Medical Association.

Such a change in any organization is bound to bring forth new problems. Many situations and questions will arise about this new membership on the basis of paying dues. In anticipation of these problems the House of Delegates of the American Medical Association has left final adjustment in the hands of the Board of Trustees. This new responsibility placed upon the shoulders of the Board will be discharged with dignified equity just as we know the individual responsibility to each of our members in the smallest of the forty-eight will be accepted and fulfilled with resigned dignity.

ANTIHISTAMINIC DRUGS

Once again the "Readers Digest" has broadcast to the uncritical general public a therapy that is declared to be foolproof and successful in its effect. The common cold is the latest victim of "medical science" and is defeated by the antihistaminic drugs. Full page advertisements in our press extol the marvelous results of pills containing these drugs, urging one and all to start taking them at the first sign of a cold. The public has responded wholeheartedly to the advertising, as every doctor and druggist can tell.

This "panic of 1949" recalls to mind similar extravagant claims made in previous years by the "Readers Digest" and advertisers. Time will no doubt settle the matter, and nothing written on these pages can hasten the day when the druggist's shelf will be stocked with another item few will buy.

In the meantime there is a pertinent aspect to the situation of which we all should be aware. Every report on the action of the antihistaminic drugs shows a definite percentage of patients who obtain the side-reaction of sleepiness, dopiness, drowsiness, etc. Depending on the actual drug and the author, this percentage varies between five and fifty percent, which means that a definite number of innocent people who take the drug without supervision are going to get into difficulty.

The whole problem has been created by a recent ruling of the Food and Drug Administration which permits the open sale of these drugs below a certain dosage. A reversal of this ruling by the Food and Drug Administration would, if nothing else, prevent a lot of automobile accidents and maybe save some lives.

MIDWINTER MEETING

Those of you who didn't go missed a mighty good time. The Midwinter meeting of the Rhode Island Medical Society in combination with the Providence Medical Association and the Newport Medical Society was a great success. First of all, it was a good day, and as most of us, of course, had to travel large Rhode Island distances to get there, we appreciated this. The weather was even mild enough to make a trip along the Ocean Drive not unpleasant. There were somewhere about 125 present, no crowding and yet a goodly group.

The Viking Hotel handled the affair beautifully. The large dining room used both for the scientific meeting and the dinner was attractive, and the beverages and viands were all that one could ask for and they were served just right. The writer of this even burnt himself with the first mouthful of steak and potatoes. You know Dr. Johnson said, "As for myself I mind my belly very studiously." And, we should not be ashamed to admit that a good meal helps out our meetings. So much for the creature comforts and the gala aspect of the affair.

The medical part was fully as satisfying. Dr. Meyer Saklad talked on the Basis of Oxygen Therapy, which was not at all stereotyped and was interestingly illustrated with unusual and convincing diagrams. Dr. Wingate Johnson came all the way from North Carolina on his first New England visit, evidently determined to make a good showing, and his talk on The Emotional Factor in the Practice of Medicine was not at all hot air but good common sense, based on practical observations with a scientific background. After dinner, Dr. Creighton Barker, of New Haven, Connecticut, reported on his recent trip through Denmark, Sweden, Norway, and the British Isles, and gave us an unbiased, factual statement of what he had observed there.

We have yet to hear from anybody who wasn't pleased that they went to this meeting.

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1950

The Trustees of the Fiske Fund announced at the annual meeting of the Rhode Island Medical Society, held in May, 1949, that they proposed the following subject for the year 1950.

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For the best dissertation on this subject worthy of a premium they offer the sum of two hundred dollars ($200.00). Each competitor for the premium is expected to conform with the following regulations:

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RESEARCH IN THE SERVICE OF MEDICINE

RHODE ISLAND MEDICAL SOCIETY, NECROLOGY, 1949

JOHN A. GORMLY, M.D., was born in Providence on October 2, 1902. After his graduation from Providence College he entered Georgetown Medical School where he was graduated in 1927. He did post graduate work at the Columbia Hospital for Women and Lying-In in Washington, D. C., and served an internship at the Georgetown University Hospital. Dr. Gormly was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association. He died on August 18, 1949.

JAMES F. MCGINN, M. D., 63, a practicing physician in Pawtucket for nearly 40 years, died December 31, 1949. Dr. McGinn was a native and lifelong resident of Pawtucket. He served on the staffs of the Roger Williams, St. Joseph's and Notre Dame Hospitals. He was born October 4, 1885. He attended St. Joseph's School and La Salle Academy, Providence. He graduated from the College of Physicians and Surgeons, Baltimore, Maryland, in 1910, and spent the following two years as an intern at the Alexian Brothers Hospital, Elizabeth, New Jersey. He then returned to Pawtucket to practice. Dr. McGinn was a member of St. Mary's parish and of the Holy Name Society of that church. He belonged to the Rhode Island Medical Society and the American Medical Association.

EDWARD L. MYERS, M.D., long active in medical and political circles in the city of Woonsocket, was born in that city December 9, 1885. He attended the city's schools, graduated from Woonsocket High School in the class of 1904 and from Tufts Medical School in 1910. In the First World War he was commissioned a captain in the medical corps of the United States Army. Besides being medical examiner, a position he had held for 13 years after serving several years as assistant examiner, he was police surgeon, a school medical inspector, and examining physician for the police and fire departments. He also served for five years as examining physician for the former State Unemployment Compensation Board on sickness benefit cases, resigning from that position last January. He was a member of the Woonsocket School Committee, having been elected to a six year term in 1944. From 1944 to 1948 he was chairman of the board. He held membership in the Woonsocket Medical Society, the Rhode Island Medical Society, National Association of Medical Associations and the American Medical Association. He was on the Woonsocket Hospital staff for 36 years, having served his internship there after graduation from medical school. Dr. Myers was 63 when he died, November 10, 1949.

MICHAEL J. NESTOR, M.D., city registrar and superintendent of the Providence Health Department for 13 years, died January 9, 1949 at the Charles V. Chapin Hospital after an illness of several weeks. A specialist in pulmonary tuberculosis, Dr. Nestor gave up the private practice of medicine when he was named to head the health department as successor to Dr. Dennett L. Richardson in 1935. A quiet, unassuming man, he was widely known and respected in the city government and in the medical profession he entered in 1905 with graduation from the College of Physicians and Surgeons in Baltimore, Maryland. Dr. Nestor was born in Westerly, March 15, 1876. He was educated in public schools there and by private tutor. Later, he entered the employ of the late Dr. Thomas I. Bannon, a veteran Rhode Island pharmacist, who advised him to undertake the study of medicine. After graduating from the Baltimore college with highest honors, Dr. Nestor served for a year as intern at the Baltimore City Hospital. Dr. Nestor is credited with fostering a general sanitation program, latest phase of which was the restaurant sanitation ordinance passed recently by the city council after months of study. Dr. Nestor set up a tuberculosis program in 1940 when the city took over that work from the Providence Tuberculosis League of which he was a member. He was a member of the Providence Medical Association, the Rhode Island Medical Society, the Rhode Island Public Health Association, which he served as president and treasurer, the American Public Health Association, and the American Medical Association. While practicing privately, he was on the staffs of the Rhode Island Hospital, the Charles V. Chapin Hospital, St. Joseph's Hospital, and the Roger Williams General Hospital. When he became superintendent, he joined the consulting staffs of those hospitals. He was an ex-officio member of the city's board of hospital commissioners and of the Rhode Island Council of Social Agencies; a member of the corporation of Rhode Island Hospital; the Providence Lodge of Elks; Tyler Council, Knights of Columbus, and the Sons of Irish

continued on page 36

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BIBLIOGRAPHY:

1. Brewster, J. M.: U. S. Nav. M. Bull. *49*:1, 1949.
2. Murray, H. G.: Indust. Med. *18*:215, 1949.

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Kings. Dr. Nestor also served as a director of the Rhode Island Infantile Paralysis Foundation and was a member of the board of trustees of the Providence District Nursing Association.

EDWIN G. THOMPSON, M.D., 86, who headed the American Red Cross expedition of Rhode Island doctors to the Halifax, N. S., disaster in 1917, died May 11, 1949 at his home after a long illness. Holder of both medical and dental degrees, Dr. Thompson was born at the disaster site and came to this country in 1889. He was graduated from the Philadelphia Dental College in 1890. He later entered the old Medico Chirurgical College of Philadelphia and received his degree in 1893. After internships at Samaritan Hospital and the Medico Chirurgical hospitals, he came to Rhode Island and practiced medicine here until his retirement in 1946. Dr. Thompson was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, What Cheer Lodge, F. and A. M. Palestine Shrine, and the Rhode Island Consistory. For many years he served as a physician for the Prudential Life Insurance Company, and the Metropolitan Life Insurance Company, and was on the visiting staff of Roger Williams General Hospital. He served as colonel in the United Train of Artillery, R.I.M., from 1924 to 1925.

STEPHEN A. WELCH, M.D., former president of both the Rhode Island Medical Society and the Providence Medical Association and only surviving member of the class of 1879 of Brown University, died September 7, 1949 at his home. He was 91 years of age. In February, 1948, Dr. Welch received a double distinguished service award from the Providence Medical Association, having served not only as president of the organization, but also as its secretary. During the Spanish-American War he served as a medical examiner of candidates for the armed forces. He served as the medical examiner for an insurance company for 49 years and was on the staff of Rhode Island Hospital for more than 20 years. Dr. Welch was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association.

JOHN A. YOUNG, M.D., 73, who practised medicine in Newport for 43 years and was physician for St. George's School and Portsmouth Priory School, died December 6, 1949 after a brief illness. Dr. Young was born in 1875, attended Rogers High School, Newport, and graduated from Classical High School, Providence. He received a Ph.B. degree from Brown University in 1900 and graduated from Harvard Medical School in 1904. He was a member of the Rhode Island Medical Society, the Newport County Medical Society, and the American Medical Association.

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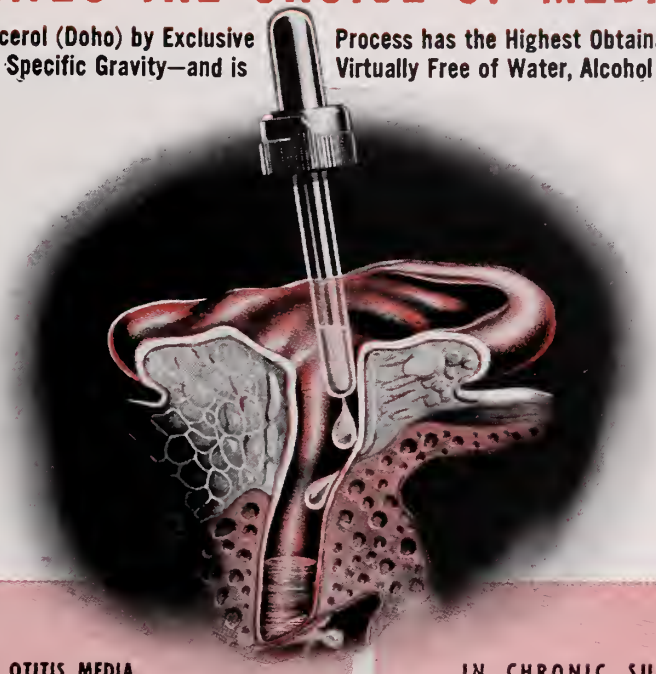
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Sulfathiazole	1.6 GRAMS
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DISTRICT MEDICAL SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

The annual meeting of the Kent County Medical Society for 1949 was held on December 15 at the Varnum Memorial Armory, East Greenwich, Rhode Island.

After a turkey dinner, the meeting was called to order at 10:20 P.M. by Dr. Arthur Hardy.

The report of the November meeting was accepted as read.

The reading of the treasurer's annual report was postponed to the next meeting, pending auditing of it by the bank.

The secretary's annual report was read and accepted.

Dr. Mack suggested an attendance roster be kept at the meetings.

The retiring president, Dr. Hardy, then gave his annual address. It was chiefly a talk reviewing the achievements of the year, including the start of the construction on our hospital, and the business like solution of the Blue Cross-Surgical Insurance program.

The nominating committee then proposed the following names for election:

President: Dr. Joseph Kent
Vice-President: Dr. Jean M. Maynard
Secretary: Dr. Edmund Hackman
Treasurer: Dr. John Mack
Censors: Dr. Royal Hudson for 2 years
Dr. Irene Maynard for 3 years
Councillor for 2 years: Dr. Arthur Hardy
Committee on Hospitals and Professional Regulations
Dr. Joseph Kent—Chairman ex-officio
Dr. Arthur Hardy—4 years
Dr. George Young—3 years
Dr. Harold Collom—2 years
Dr. Joseph Wittig—1 year

Dr. George Young moved that the secretary cast one ballot electing these officers. It was seconded by Dr. Tefft and so voted.

Drs. Young and Hudson then escorted Dr. Kent to the chair.

The by-laws were again brought up and are nearing completion for a reprint.

Dr. George Young reported about his talk with the V. F. W. and announced that Dr. Orland Smith will be invited to talk to them about a blood bank for the new hospital.

Dr. Tefft moved that the meeting adjourn, and it was seconded and so voted at 10:45 P.M.

Respectfully submitted,
JEAN M. MAYNARD, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kent County Medical Society for November, 1949, was held on the 29th at the office of Dr. Peter Erinakes.

There were 13 members and 1 guest speaker present. The meeting was called to order at 9:30 P.M. by the president Dr. Arthur Hardy.

A new by-law, re: Committee on Hospitals and Professional Regulations, was added to the Constitution after a motion made by Dr. Abbate, and seconded by Dr. Koch, that this by-law be accepted after correction of a typographical error.

Progress was reported on the compilation of the by-laws for a new reprint.

The trustees of the Kent County Memorial Hospital notified Dr. Hardy that the Veterans of Foreign Wars of East Greenwich are offering an iron lung for the new hospital. It was pointed out that one could be obtained on request from the National Foundation. Dr. Abbate made a motion, seconded by Dr. Hudson, that the chair appoint someone to speak to the V. F. W. at their next meeting and propose an alternative gift, such as a blood bank. Dr. Young was appointed for this task.

The committee for the annual meeting to be held next month was then appointed by the chair. It comprises Drs. Taggart, Young and Mack.

The chair also appointed Drs. Taggart, Hudson and Farrell as the nominating committee for election of officers for next year.

Dr. Charles Farrell, chairman of the "Committee on Public Policy and Relations," spoke about the role of the individual doctor in the campaign against socialized medicine, and indicated that opposing socialized medicine is opposing socialism as a whole. Public relations serve to make the public conscious of the doctor's role and position in the community. He mentioned different publications regarding socialized medicine, especially "American Medicine and the Political Scene", a timely pamphlet written

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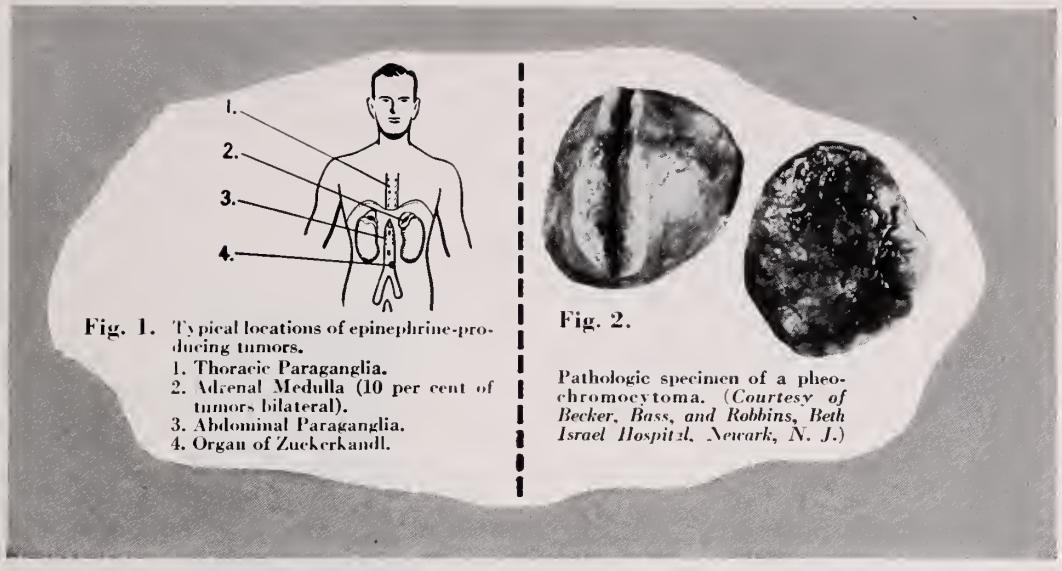


Fig. 1. Typical locations of epinephrine-producing tumors.
1. Thoracic Paraganglia.
2. Adrenal Medulla (10 per cent of tumors bilateral).
3. Abdominal Paraganglia.
4. Organ of Zuckerkandl.

Fig. 2.

Pathologic specimen of a pheochromocytoma. (*Courtesy of Becker, Bass, and Robbins, Beth Israel Hospital, Newark, N. J.*)

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KENT COUNTY SOCIETY MEETING

continued from page 38

every week by Marjorie Shearon. He described what certain county societies were doing and remarked briefly on the state of medicine under socialism in England.

Dr. Farrell then made the following suggestions: Every member should first support his county and state society by paying his dues, and give a concerted effort in this respect; county societies should send one man as a delegate or counselor to national meetings of county societies to keep posted on current events and learn what others are doing; subscribe to different publications; and, have local newspapers print cartoons and reprints on socialized medicine.

To end, Dr. Farrell played a transcription of a speech made by Marjorie Shearon concerning the bill HR 6000, which she gave last fall in Providence at the Medical Library.

A rising vote of thanks was accorded to Dr. Farrell for his interesting and enlightening remarks, and the meeting adjourned at 11 P.M.

Respectfully submitted,

JEAN M. MAYNARD, M.D., *Secretary*

WOONSOCKET DISTRICT MEDICAL SOCIETY

The first winter meeting of the Woonsocket District Medical Society was held on December 6, 1949, at the Club Canadien. The meeting was opened by the President, Thomas J. Lalor, M.D., at 9:30 P.M. Minutes of the last session were read and approved and a letter of appreciation from Mrs. Edward L. Myers was presented.

There was a discussion of the Emergency Medical Care Set-up and a motion was made and approved that the period to be covered on Sunday would be from 7:00 A.M. until 7:00 A.M. Monday.

The President appointed Drs. F. J. King, J. Reilly, and G. Keegan as a nominating committee to present a slate of officers for the coming year.

Dr. Robert Hayes, representing the Public Relations Committee of the Rhode Island State Medical Society, was introduced and he presented plans for the furthering of the Public Relations Program with relation to the Welfare Legislation called for by the present National Administration. He stressed the importance of meeting the public demands for Emergency Medical Care and the need for establishing better relations with the press. His talk covered the development of trends toward the National Compulsory Insurance. Excerpts from a speech, recorded by Marjorie Shearon, on the development of the Socialized State, were reproduced on the recording machine.

The Nominating Committee presented the following slate of officers: President—Dr. Leo Dugas; Vice-President—Dr. Alfred E. King; Secretary—Dr. Emil A. Kaskiw; Treasurer—Dr. Paul Boucher. House of Delegates: Drs. George Keegan, Joseph McKenna. Councillor—Dr. T. J. Lalor; alternate—Dr. Augustine Eddy. Censors: Drs. Francis J. King, Alton P. Thomas, George A. Crepeau. A nomination was made and adopted that the slate be approved and unanimously elected.

The meeting was adjourned at 11:00 P.M.

A buffet supper was served.

Attendance 27.

Respectfully submitted,

ALFRED E. KING, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

Seventeen members attended the November 22nd meeting of the Newport County Medical Society held at the Newport Hospital. It was called to order at 9:15 p.m. by Dr. Philomen P. Ciarla.

One communication was read. Drs. H. William Taylor, Rupert Von Trapp and Phillip McAllister were admitted to the Society. The applications for membership of Drs. Lorenzo Orlando and John E. Carey were referred to the Board of Censors.

Dr Osmond Grimes moved that a committee be appointed to revise the by-laws and application forms. Dr. Samuel Adelson amended this to have the committee made up of the President and Secretary of the Society. The motions were seconded and passed.

Dr. Charles Farrell, our guest speaker, spoke on the Public Relations of County and State Medical Societies.

Collation followed.

Respectfully submitted,

JOHN M. MALONE, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held on November 17, 1949, at 6:15 p.m. in the Nurses' Dining Room of Memorial Hospital. This was a dinner meeting and sixteen members attended.

Dr. Dante Chiappinelli and Dr. Rudolph Alexander Jaworski were unanimously elected to membership in the Association.

Dr. Albert Gaudet moved that the Association go on record as being opposed to the newly enacted Medico-Legal Laws of Rhode Island in certain respects, particularly as regards the Chief Medical Examiner and the number of Deputy Examiners. This motion was passed. The Secretary was instructed to write to the Attorney-General and to the House of Delegates of the Rhode Island Medical

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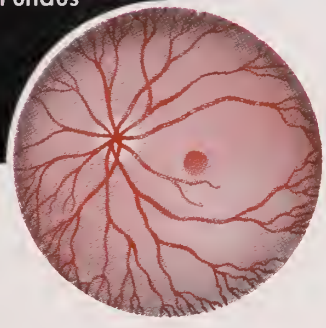
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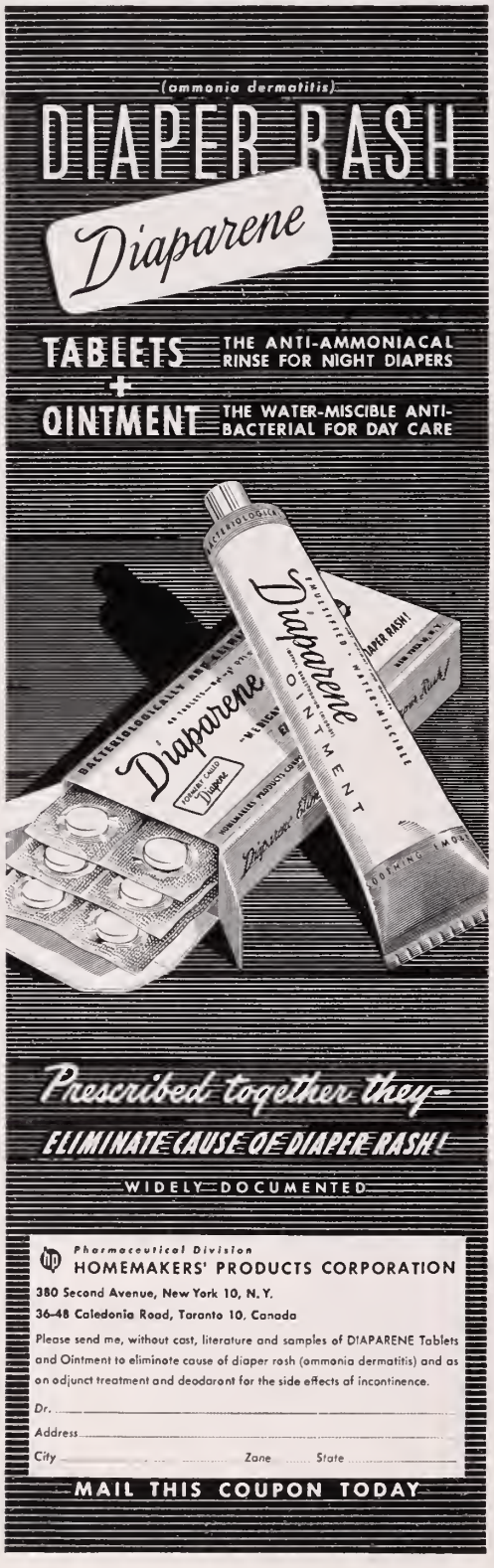


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PAWTUCKET MEDICAL SOCIETY

continued from page 40

Society expressing the desire of the Association to have the deficiencies corrected as far as possible.

The meeting then adjourned to the Nurses' Auditorium where the chairman, Dr. Charles L. Farrell addressed the group on "Public Policy and Relations."

Dr. Farrell made a plea for more active participation in the affairs of the Medical Society and also of the community. Emphasizing that we are citizens as well as doctors, he said, "Be informed, read Marjorie Shearon's reports, make your influence felt. Don't talk Socialized Medicine, talk Socialism. Recognize parts of the whole picture. And keep your eyes on current legislation, particularly HR 6000".

The meeting adjourned at 10:15 p.m.

Respectfully submitted,

K. W. Hennessey, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 7, 1949. The meeting was called to order by the President, Dr. George W. Waterman, at 8:40 p.m.

The Secretary read the minutes of the previous meeting of the Association.

There were no reports of committees and no communications.

Dr. Waterman reported that the Association would not meet in December in Providence, but instead would meet jointly with the Rhode Island Medical Society for its Midwinter meeting to be held at the Viking Hotel at Newport, Rhode Island, on Wednesday, December 14. He urged the attendance of all members at this session.

Dr. Waterman introduced as the first speaker of the evening Dr. Thomas Perry, Assistant Surgeon, Out-patient Department, at the Rhode Island Hospital, who spoke on "CARCINOMA OF THE TONGUE." Dr. Perry stated that carcinoma of the tongue occurs in the usual age group in cancer. 90% are males. In cancer of the floor of the mouth 86% are males whereas in the buccal mucosa 96% are males. Primary cancer is almost never found around the circumvallate papillae. Since ¼ of the patients have a positive serology, it is probably related to luetic glossitis.

. In cancer of the lip, 80% are grade 1, but in the tongue only 19% are grade 1. Therefore the prognosis is bad.

The end results of his study show that in 95 cases, only 15 had three year cures or 15.8%. 10 had a five year cure with 11.9%. Of 95 cases, 33 were so bad, palliation only was given.

Of the 62 cases treated for cure only 15 had surgery, 47 had radiation only with a cure rate of 23.3%. The local lesion was cured by primary treatment in 10 cases, 7 by radiation, 3 by surgery.

Only 14 cases had a lesion of less than 2 cm. 50% cure was obtained in this group. Many of the tumors are on the posterior 1/3 of the tongue, and are painless so that the patient is unaware of it, hence the large size when first seen.

13 cases had neck dissection, one a bilateral one. One case is living and well seven years after positive nodes were found.

How can we improve these figures? A younger individual with good size tumors should have a prophylactic neck dissection. We now feel that surgery has more to offer than before when x-ray and radium were more popular. Even a total glossectomy can be done if necessary.

In the discussion, Dr. Cameron said that the higher percentage in males was due to syphilis (25%), tobacco, and poor dental hygiene. He emphasized the fact that the 50% three year cures were in early cases in which the lesion was less than 2 cm. Over 47% had neck nodes when first seen. Later 20% developed them while under treatment.

Dr. Chase stated that the mortality rate did not tell the entire story. Many died with a clean mouth from other causes.

Dr. Gibson showed two cases of radical neck and jaw dissection he had done with excellent results.

The second speaker of the evening was Dr. Seebert J. Goldowsky, assistant surgeon at the Rhode Island Hospital, who spoke on "SPONTANEOUS RUPTURE OF THE ABDOMINAL AORTA WITH REPORT OF A CASE."

Dr. Goldowsky presented a history of a case of ruptured abdominal aortic aneurysm. Patient was seized with generalized abdominal pain and dyspnea, and then stupor set in. Abdomen revealed an enlarged liver, but no tenderness or spasm. Several hours later distension set in. White blood count was 40,000. Electrocardiogram was negative. On the seventh day after drinking water, he experienced abdominal pain, became cyanotic, blood pressure dropped to 40, and he expired in thirty minutes. At post mortem a saccular aneurysm with rupture was found with retroperitoneal hematoma

He drew our attention to this condition in the differential diagnosis of the acute abdomen. Luetic aneurysm has disappeared with progress in the treatment of syphilis. There is now more frequent appearance of atheromatous aneurysm due to pro-

continued on next page

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PROVIDENCE MEDICAL ASSOCIATION

continued from preceding page

longation of life in older people. This can be of the dissecting, saccular, or fusiform type. The abdomen is rigid at onset, later ileus and distension appears.

At times the symptoms suggest renal calculus, due to rupture in the peri-renal area. Some cases simulate ruptured gastric ulcer.

From 1938 to 1948, there were ten cases in the Rhode Island Hospital. Duration of survival was five hours to fifteen days. Abdominal pain was present in all ten cases. Nausea and vomiting occurred in five. Bowel changes were variable as was weakness and prostration. Shock was present in all. Abdominal mass was palpated in six. All had elevated white blood counts. In only one x-ray was aortic change noted. Abdominal exploration was done in two instances with the finding of retroperitoneal hematoma. Two cases of ruptured thoracic aorta in the files also had abdominal pain.

Blakemore now uses wiring and electrothermal coagulation. The interval of two to four days after onset gives a good opportunity for surgery.

Dr. A. Henry Fox in the discussion stated that the pain in this condition can be very severe, comparable to the pain of occlusion of a major vessel of the leg. The incidence of the disease in the sixty to seventy age group should make us suspect it in these patients with abdominal pain. A very high white blood count directly after the onset, that recedes in a day or two indicates rapid hemorrhage.

Dr. Robert Baldridge suggested x-ray demonstration of the aneurysm by injecting radio-opaque media. Hippuran injection of the aorta while requiring special skill can be done for diagnosis.

The meeting adjourned at 10:50 p.m.

Attendance was 78.

Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

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BOOK REVIEWS

ADVANCES IN INTERNAL MEDICINE, vol. 3. Edited by William Dock and I. Snapper. Interscience Publishers. N. Y., 1949. $8.50.

VOLUME THREE of the series "Advances in Internal Medicine", as in the preceding two volumes, consists in a series of monographs. The subjects are varied and serve the avowed aim of the series, to brief the internist, other specialists, and the general practitioner on outstanding recent advances in internal medicine and related fields.

The initial chapter on the use of BAL, as British Anti Lewisite is abbreviated, covers the theoretical background associated with the development of this compound. BAL resulted from an intensive search for an antidote against arsenical war gases, begun in 1939 in the laboratories of Professor R. A. Peters at Oxford. The compound, 2, 3-dimercapto 1 propanol (BAL) proved to have such a high affinity for arsenic that it was possible to reverse virtually all of the acute biologic effects of arsenical toxicity in animal experimentation. A very interesting description of the use of BAL in the treatment of arsenical intoxication in man follows. Arsenical dermatitis, encephalitis, and various blood dyscrasias, associated for the most part with anti-luetic therapy, were all found to benefit greatly from the use of BAL. These promising results led to its use in other forms of metallic poisoning. It was found to be life saving in cases of mecurial ingestion, and greatly beneficial in toxicity from other metals, including gold, antimony and bismuth. The mortality from lead poisoning, however, appeared to be actually increased by the use of BAL, and it was ineffective in thallium poisoning and argyria.

The chapter entitled "Current Concepts of Hemolytic Anemias" By Estren and Dameshek offers a worthwhile review of the basic principles involved in physiologic and pathologic hemolysis, and summarizes current concepts of some of the major hemolytic syndromes. Theories concerning the usual mechanisms of hemolysis are presented, and the role of the spleen and other portions of the reticulo-endothelial system discussed. The various hemolytic syndromes are considered, including the hereditary-congenital types, spherocytosis, sickle cell and target cell (Mediterranean), as well as the "idiopathic" acquired hemolytic anemias. In this latter category, the treatment of erythroblastosis fetalis and its immunological background Rh, is unusual for its simplicity and clarity. Finally the concept of hypersplenism is discussed.

A chapter entitled "Factors Modifying Penicillin Activity" is included. The multiplicity of the penicillin species, and their varying bactericidal activity are described, as well as the absorption, excretion, and distribution of penicillin in the body. Various factors modifying the activity of penicillin are also discussed.

A discussion of the treatment of tuberculosis by streptomycin follows. The early work in this regard was of course carried out in animals, and following this experimental work in human tuberculosis was carried out. The authors review their experiences at the Mayo Clinic, Mineral Springs Sanatorium, and the Rochester State Hospital. The effects of streptomycin therapy on the various types of tuberculosis, the gratifying response of tracheobronchial and laryngeal tuberculosis, the unpredictable response of pulmonary tbc, and the rather small percentage of tuberculous meningitis cases salvaged are described. Incidentally the authors advise combined intramuscular and intrathecal administration for tuberculous meningitis. Frequent remissions were observed, but relapses were also frequent, and actual cure was obtained in relatively few. It appears that streptomycin, while useful, falls short of the ideal tuberculochemotherapeutic agent.

The chapter on Histoplasmosis represents a fairly complete description of this disease. The first case was described by Darling in 1906. On the basis of this and two subsequent cases, he described the outstanding clinical features as irregular fever, emaciation, anemia, leukopenia and splenomegaly, which concept largely holds true today. Since this time, many more cases have been reported, two of which are based on autopsy material from hospital files 13 and 21 years after the autopsies were performed. 81 cases were reported up to 1945, 56 of which were in the United States, and there appears to be a particularly high incidence in the midwestern part of this country. In approximately one third of the reported cases, diagnosis was established during life, and in the majority of the other cases, diagnosis could have been made while the patient was alive if the condition had been suspected. Diagnosis by biopsy has been the most successful of all diagnostic methods, enlarged

continued on page 49

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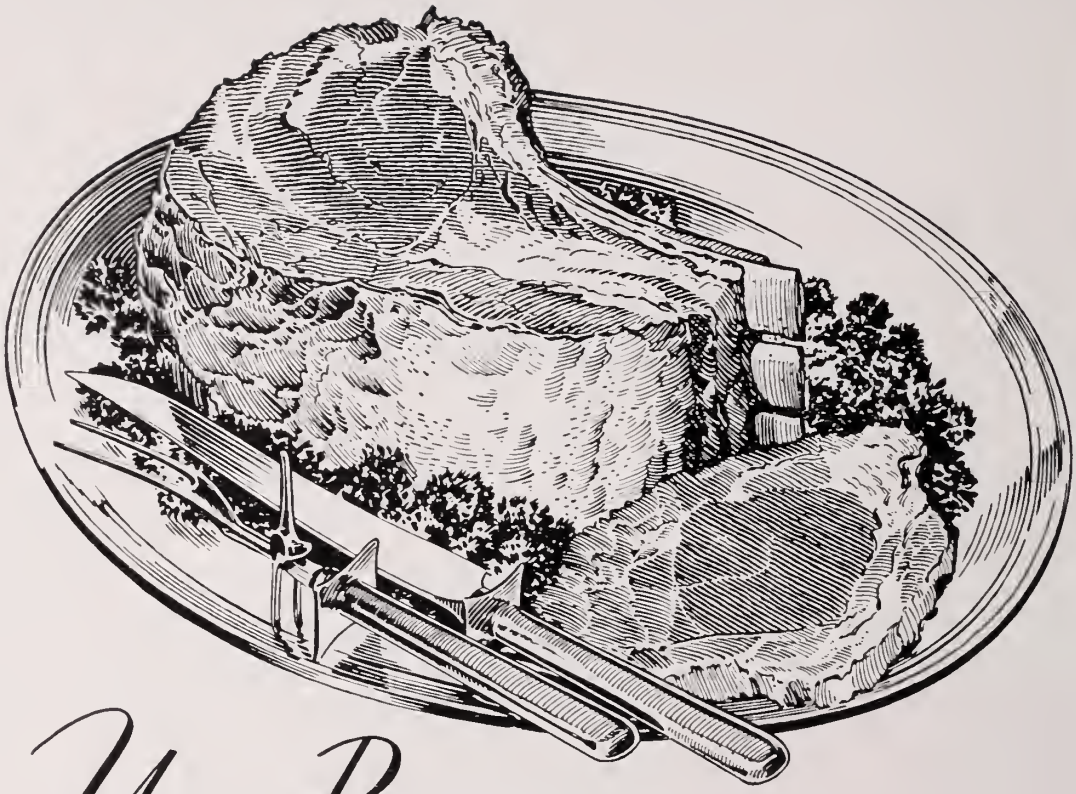
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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (April 2) 1949.

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BOOK REVIEWS

continued from page 46

superficial lymph nodes and superficial lesions of the skin or mucous membrane being most readily examined. A detailed picture of the clinical and pathological features is included. No effective treatment is available as yet.

The treatment of hyperthyroidism with antithyroid compounds is exceptionally well covered in a monograph by Astwood. The theoretical mechanism of action of these compounds is reviewed in detail, and the various antithyroid substances are critically compared. The section on nodular goiter is most interesting. The author feels that while Graves disease and toxic adenomatous goiter differ in their most classic forms, many cases cannot with certainty be placed in one or the other group. Further it was recently shown that it is not the nodules in adenomatous goiter but rather the intervening tissue that is hyperactive. He feels therefore that it is impractical and possibly unwise to regard these two clinical variants as two different diseases. Experience with antithyroid therapy has not aided in making a distinction between the two conditions, as the response to treatment may be identical.

Iodine medication is discussed, and it is pointed out that the delayed response to anti-thyroid drugs following iodine therapy may be a serious matter. He warns that any physician who prescribes iodine for the treatment of hyperthyroidism should do so in full realization that should it fail, a difficult therapeutic problem will present itself. As far as the concurrent administration of iodine and antithyroid medication is concerned, he feels that relapses are more frequent with this therapy, and that iodine should be avoided entirely. Astwood's views regarding therapy for nodular goiter and iodine medication conflict rather sharply with those expressed by Dr. Cyrus Sturgis of the Univ. of Michigan while on a recent visit here. The entire discussion is clear, refreshing and informative.

Diagnosis of Disease by Enzymic Methods discusses the association of bodily disease and changes in the serum content of enzymes. The chapter furnishes a good review and integration of the action of enzymes, and their importance in clinical diagnosis. The significance of the acid and alkaline phosphatase values in prostatic carcinoma, and the elevation of zymohexase in other types of cancer are among the clinical features discussed. A list of enzyme changes in disease is included.

Janeway's article on plasma fractionation is of interest. This work was done largely during the war, with several private and governmental agencies pushing the project. The material was supplied by the blood donor service of the Red Cross. The methods of fractionation are described, and the

continued on next page

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BOOK REVIEWS

continued from page 49

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A chapter on the Mechanism of acclimatization to heat sets forth the physiologic adjustments by which man adapts himself to increased temperatures. The mechanisms by which these adjustments are made, not having been known, were carefully worked out by the author. Apparently, the process of acclimatization to heat consists essentially in an increased activity of pituitary adrenocorticotropic hormone with resultant production and liberation of adrenal cortical steroids. These latter substances are responsible for the improved peripheral circulation and conservation of body salt which underlie acclimatization.

The final chapter is a summary of medical progress in neurologic therapy. The status of the treatment of some of the more common diseases of the nervous system is discussed in a highly creditable fashion.

JOHN A. ROQUE

CARE OF THE SURGICAL PATIENT by Jacob M. Fine. W. B. Saunders Company, Phil., 1949. $8.00.

As stated by the author, this book is not a textbook of surgery, but rather a guide to the over-all care of the surgical patient. Although it should be a helpful text for any practicing surgeon, it will find its greatest field of usefulness in the hands of medical students and of surgical internes and residents.

Its 52 chapters are grouped into six general sections, the titles of which give a fair indication of its range and scope. Section I on General Considerations contains chapters of fluid and electrolyte balance, nutrition and surgical infections. The various systems and surgical specialties are covered in Section II, entitled Regional and Special Surgery. Section III is devoted to the Endocrine Diseases and Hormone Therapy. Coincidental medical illnesses such as cardiac disease and diabetes mellitus are discussed in Section IV. Section V outlines various clinical and laboratory procedures of established value, while Section VI describes the preoperative and postoperative care of the surgical patient.

The author's keen and logical mind is displayed to advantage in those portions of the text concerned with problems in general surgery, where his personal experience is widest and particularly in discussions on applied surgical physiology, in which he excels. The surgical specialties, such as neurosurgery, nose and throat, gynecology, orthopedics, plastic and pediatric surgery, treated in a fashion which is often superficial and elementary, might well have been approached from a more authoritative viewpoint. In view of the availability of excellent textbooks and monographs on these subjects, this space might well have been devoted to other matters.

On the whole, however, this volume can be well recommended as a useful addition to the surgeon's library.

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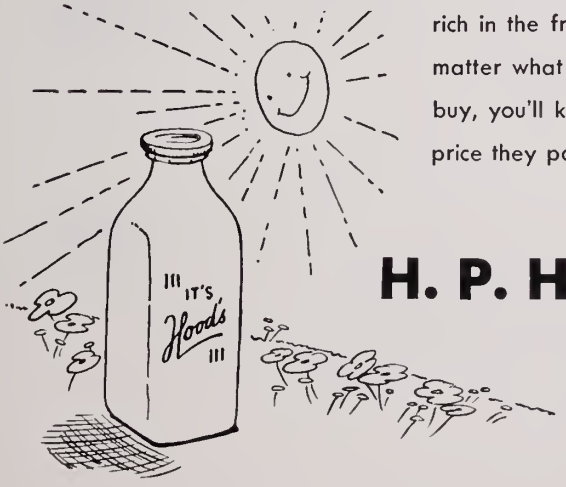
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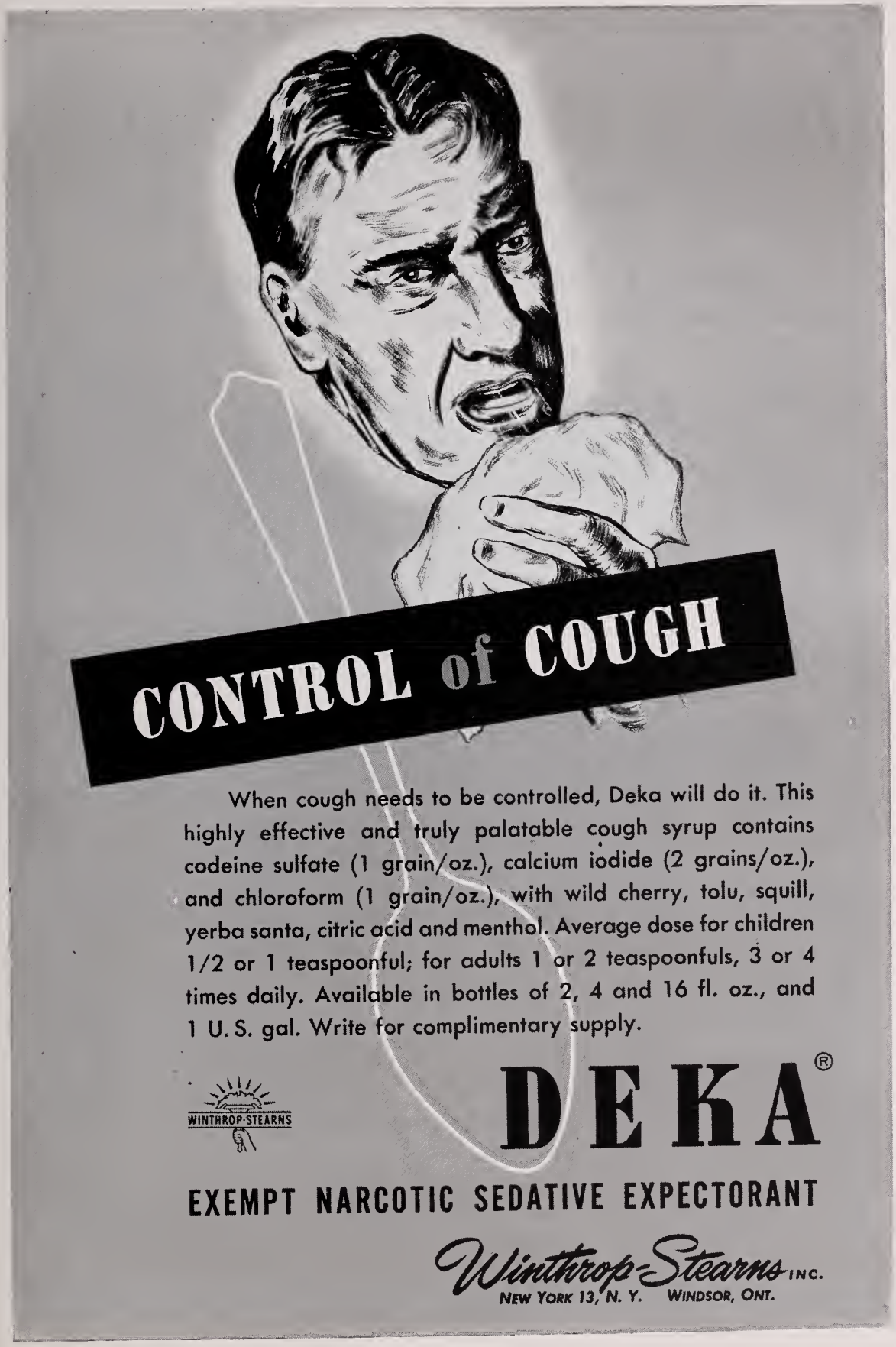
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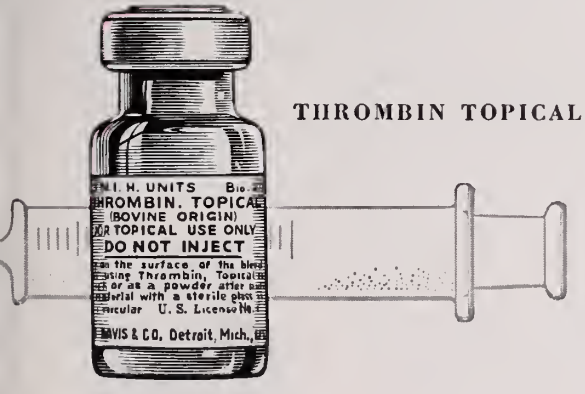
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1. Rogers, Max P.: J.A.M.A., May 21, 1949
2. Wyatt, Bernard L.: Ann. West. Med. & Surg., Aug. 1949
3. Grimson, Marzoni, Reardon & Hendrix: Ann. Surg., 127:5, May 1948

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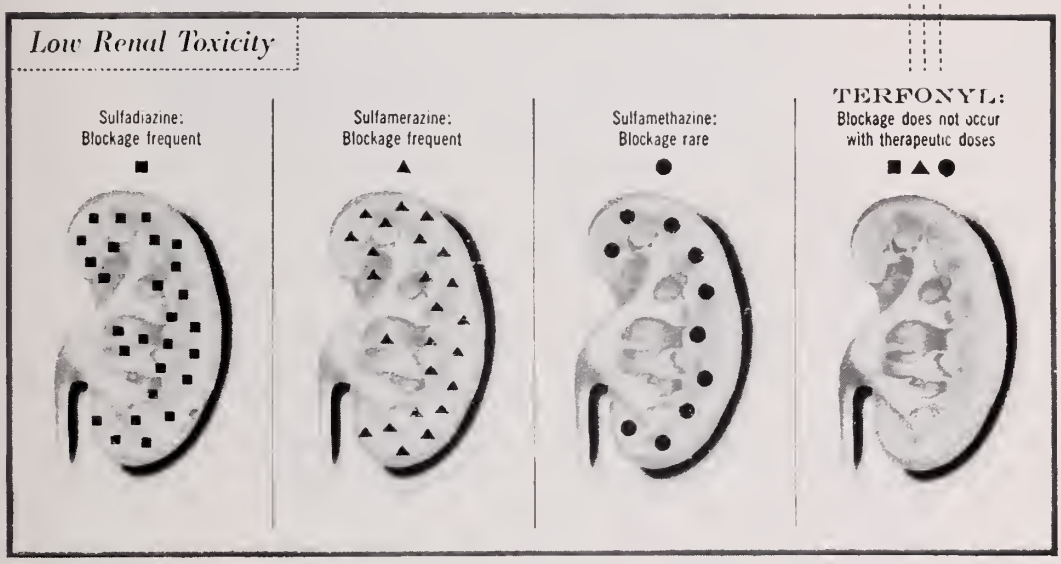
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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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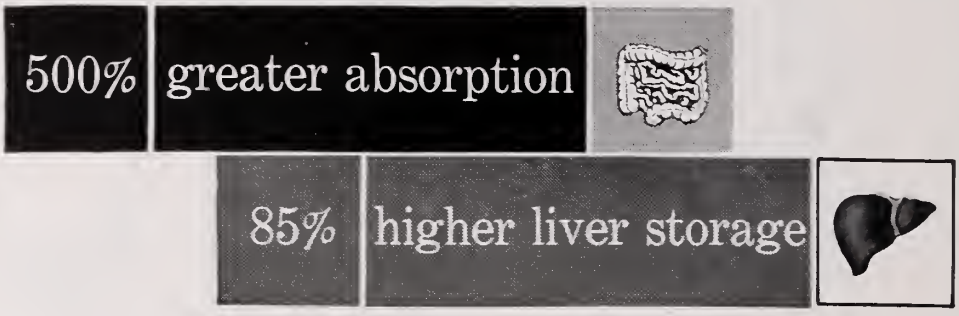
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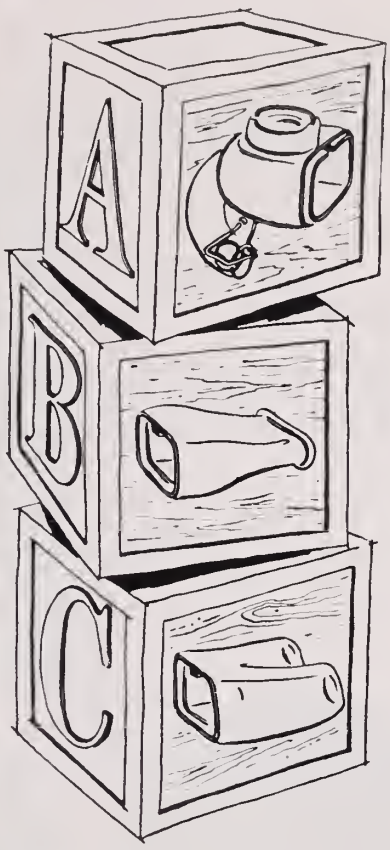
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1. Krasna, L. R., and Rhoads, P. S. (1949), The Inhalation of Penicillin Dust; Its Proper Role in the Management of Respiratory Infections, Amer. Prac., 11:649, July.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXIII FEBRUARY, 1950 NO. 2

THE PROVIDENCE MEDICAL ASSOCIATION — 1949*

Annual Address of the President

GEORGE W. WATERMAN, M.D.

THE BY LAWS of this association require a presidential address on the occasion of the annual meeting. This year I propose to review the activities of the society during my term of office, to note some important events which have occurred in the past year of concern to the society, and to make some comment on these events. Also, from my experience of the past year, I shall make some suggestions and recommendations for future action by the society.

Meetings

During the past year the Providence Medical Society has held six regular meetings, at which scientific papers have been read and at several of which we have had speakers to inform us of community activities and in which current socio-economic problems have been discussed. The meetings have been well attended, 90 as an average. Two meetings were held together with the State Society, the first at Quonset in February at which we enjoyed the hospitality of the Navy. An excellent program was put on for us including inspection of the aircraft carrier Kearsarge. A cocktail hour and dinner and an excellent scientific program concluded the evening. In December we met with the State Society at Newport as guests of the Newport Society. We all enjoyed a good social and scientific program and a fine dinner. In March we had speakers representing the Red Cross of Rhode Island. Dr. Kingman of our association told us about the really extensive work that is carried on rather quietly by this organization. Mr. Slader of the Red Cross spoke on the programs of instruction. Chief Bonat of the State Police spoke of the importance of first aid training in police work. Mr. Charles Quinn of the Governor's Fire Prevention Conference, Committee on Rescue and Disaster spoke of his work in the training of rescue units in the state and asked for the cooperation of the Medical Society in the supervision of disaster squads and the keeping up of proper standards in first aid. In May Dr. Sullivan, the director of the new Veterans Hospital talked to us of the hospital, its lay-out and plans for operation. This hospital was subsequently opened for reception of patients several months later. The association is honored by having three of its members as Chief of Departments, Dr. Clarence Bird as Chief of Surgery, Dr. Herman Lawson as Chief of Medicine and Dr. Robert Williams as Chief Pathologist.

Special Meeting

In September, 1949, a special meeting of the society was called on petition of members as provided in the by-laws. The purpose of this meeting was to have a free and open discussion of the controversy between the Hospital Service Corporation (Blue Cross) and our Physicians Service Committee (Rhode Island Medical Society). At the time of this meeting negotiations between the two committees had apparently broken down. There was much criticism of members of the committee by the press and some grumbling among the members of the society. At this meeting the entire history of negotiations was reviewed, and after a most interesting and stimulating meeting with discussion by many members, an overwhelming vote of confidence was given to our committee. I believe that the action of the society expressed at this special meeting so strengthened the hand of our negotiators that within a few weeks a successful and satisfactory conclusion was reached whereby Blue Cross would do the merchandising for the Rhode Island Medical Society Physicians Service Corporation's Surgical-Medical Insurance contract. This meeting demonstrated again the great value of free discussion in ironing-out of mis-

continued on next page

*Delivered at the 103rd Annual Meeting of the Providence Medical Association, at Providence, R. I., January 9, 1950.

understandings and difficulties. We now have as a result of this program with the Blue Cross, and of the "Rhode Island Plan" which utilizes the private insurance companies, a wide latitude of coverage in prepayment-health insurance in this state. Every member of our association should cooperate fully in the advancement of these nonprofit programs. I urge every member who has not already signed the Participating Physicians Agreement to do so.

To the members of the Physicians Service Committee and especially to the members of our association who played a major part in this study and negotiotions and who, by their patience and perseverance in the face of much adverse criticism, have brought their negotiations to a successful conclusion, our deepest appreciation is due for a job well done.

Committee Activities

The Providence Medical Association has many committees which cover various activities within the society and others which have to do with its relations outside the society. The activities of these committees vary from year to year in importance and amount of work but all are set up and ready for action when the occasion arises. I shall speak of the work of a few of the more active in the last year.

1. *Air Pollution*—The efforts to clear the air of Providence is a direct result of the activities of the association which touched off the campaign for anti-air pollution five years ago under the presidency of Dr. B. Earl Clarke. The Citizens' Committee, subsequently organized by the association, aided in the adoption of legislation whereby an adequate staff has been employed to supervise smoke pollution in the city. The task is not one to be completed in a year, or even several years. It represents an unending work of public education and close surveillance to prevent violation of the codes. The result has been progressively gratifying and certainly will ultimately make for healthier living in our city. The association continues its interest in the work through an active Air Pollution committee which acts in both a consultive and advisory capacity to the city government.

2. *Food Handlers*—The Legislative committee headed by Dr. Frank B. Cutts two years ago initiated action which resulted in the adoption by the city of Providence of a more effective food handlers' code. This ordinance has resulted in a decided improvement in the control of the sanitary procedures of eating and drinking establishments in greater Providence and certainly adds another link in the preventive disease campaign which will make for less ill-health among our citizens.

3. *Medical Milk Commission*—For many years the association has maintained a Medical Milk Commission which operates in the task of supervising milk processed and sold under the caption of "Certified Milk." The strict control of dairies operated with the Commission and of the workers employed in such dairies, has provided the most effective guarantee possible regarding milk. The controversy evoked by the Providence Journal-Bulletin during the year relative to the milk sold in greater Providence and throughout Rhode Island significantly made no reference to the work of the Providence Medical Association's Medical Milk Commission, nor to the fact that the milk sold under this supervision was the best protected in the community.

4. *Health and Accident Insurance for Physicians*—The same committee of the association which prepared in 1940 an insurance policy digest for physicians of which more than 6,000 copies have been distributed on requests from all states in this country, reviewed the various group insurance contracts available and recommended the adoption of one this year for our members. As a result approximately 300 physicians have enrolled in the new group policy of the association. To this committee we are greatly indebted for their efforts in our behalf.

5. *Diabetic Detection*—Two significant programs carried out this past fall were the Diabetes Detection campaign under the direction of the State Society headed by Dr. Louis I. Kramer of our association and the Cancer Conference of the State Society arranged by the cancer committee. The first program aimed towards public education resulted in more than 6,000 persons accepting the offer of free examination to detect diabetes and this public education work entailed the donation of the services of physicians, technicians and laboratories.

6. *Cancer Conference*—The cancer conference, the second annual meeting for physicians, attracted more than 150 doctors to our state medical library for lectures on cancer detection and care by outstanding authorities.

7. *Entertainment*—Not the last, and certainly not the least of our active committees is that titled the Entertainment Committee. Busy physicians take too little time for relaxation and rest and the constantly enlarging field of medical economics bears clear testimony to the increasing demands upon our time and energies. Hence, it is notable that we get together at least once during the year for an informal dinner and entertainment which is annually made an outstanding success by the untiring efforts of this committee which includes in its personnel such workers for the association and the

profession as Dr. Nate Bolotow and Dr. Herman Grossman. To these men and their cohorts we are truly appreciative for the job they do so well for all of us each year.

8. *Telephone Bureau*—Undoubtedly the finest step taken by the association this past year has been the establishing of a 24-hour secretarial bureau to handle the telephone calls of physicians. The work of this new Medical Bureau, located in the State Medical Society library and under the direction of Mrs. Beagan, has demonstrated its value in the short time it has been in operation. Its efficient and complete service has exceeded our hopes for an organization just starting out and to Dr. John G. Walsh and his committee who handled all the preliminary work and who have guided the Bureau off to such a fine start, we are grateful.

As a service to physicians the Bureau is proving indispensable. At the present time there are 175 direct lines to the Bureau which tie in the telephones to physicians' offices. In addition a direct line is maintained with the Providence Police Department and to several of the larger hospitals in the city.

No effort has been spared by the Committee in seeking ways to make this new service the finest possible. Seven operators constitute the Bureau staff and the average number of telephone calls handled weekly is 7,300. That gives you some idea of the volume of work done by the Bureau for us.

In addition, the Medical Bureau has answered a vital community need. Since its start 330 emergency calls have been answered day and night. In every instance a physician has been secured for an emergency. To the doctors who have answered these calls I cannot offer enough praise. They represent the true service that the profession has pledged itself to render and they have, in my opinion, been our finest public relations personnel.

Disaster Committee

There is one field in our relations with the public which does not appear to be represented by a committee of this society. As far as I can find out we have no Disaster Committee. In this atomic age much thought is being given nationally to Civilian Defense. It would seem to me that this society should be ready through a Disaster Committee to act with other agencies, such as the Red Cross, Police and Fire and Hospital authorities, to contribute its part in civilian defense programs. I know that Mr. Slader of the Red Cross and Mr. Quinn of the Governor's Fire Prevention Conference, Committee on Rescue and Disaster are ready and anxious to have our cooperation in their training programs. I would recommend that such a committee be appointed to confer with these organizations and to consider in what way our society can be useful.

Compulsory Health Insurance Issue — National Level

When I took over the gavel from Phil Batchelder January, 1949, the year ahead looked full of storm clouds for American medicine. The 81st Congress had just assembled and Mr. Truman was about to be sworn in as President after an overwhelming victory at the polls in November. Oscar Ewing's report to the President recommending compulsory health insurance was on the books and socialized medicine seemed on its way.

In spite of all the scientific progress in American medicine resulting in the saving of untold number of lives, in spite of improved standards in hospitals and educational opportunities for doctors resulting in better patient care, the public relations of the doctors as a group seemed at a low ebb. The individual doctor, hard-working, absorbed in his scientific studies and in the exacting demands of sick patients had no time, or thought he had no time, to defend himself or to sell himself to the great public. Few doctors have a call to enter the political arena. Naturally conservative and a little slow to abandon the old and tried for the new and untried, the leadership of American medicine may have made some mistakes by being over-conservative in the face of the growing liberalism of the day. With the threat of socialization of medicine, with all its regimentation, which they had seen overtake their brothers in England, threatening the breakdown of much that they held dear, American medicine arose. The great campaign by the A.M.A. of 1949 against compulsory health insurance was about to start. That this campaign was successful in 1949 does not mean that some form of socialized medicine may not come in 1950 or later. The point of the matter is that the American doctor has been alerted, the A.M.A. has a program, and the people of the country have had the doctor's case presented and will continue to be educated in the facts of medicine in all its relations to the public health.

The Assessment of Dues by the A.M.A.

In order for our great national society to function in all its varied activities, and one has but to read the organization sections of the Journal to realize how varied and far-reaching the activities of all our committees and conferences are, the society by its democratically elected House of Delegates has voted that annual dues of $25.00 be assessed on each doctor. This tax is just and necessary to my thinking and should be borne willingly. Our A.M.A. is indispensable if we are to deal with the politicians who would soon socialize and regiment us without it.

During the past year when it has been my duty and privilege to have to do with arranging programs

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LINEAR PSORIASIS

Report of a Case

ARTHUR B. KERN, M.D.

The Author. *Arthur B. Kern, M.D., of Providence. Assistant Dermatologist, Department of Dermatology, Rhode Island Hospital.*

THE PRESENTATION of a patient with a linear dermatosis usually evokes discussion concerning nevus unius lateris, lichen striatus, lichen planus and psoriasis linearis. Numerous articles about the first three have appeared. However, a review of the literature showed that linear psoriasis has seldom been reported. Howard Fox, on several occasions,[1, 2] mentioned the infrequency with which he has seen cases of this type. Woringer[3] has stated that linear psoriasis is an extremely rare variety of a very commonly observed disease. Linear psoriasis appearing at the early age of six months is even more rare. In view of this, the following case report was deemed worthy of publication.

Report of a Case

A. K., a four year old white girl, was first observed to have a cutaneous lesion at the age of six months. This appeared on the posterior aspect of the right thigh and then gradually spread proximally and distally. Subsequently, some areas underwent spontaneous involution, leaving residual depigmentation. The lesions were on occasion slightly pruritic. At about the age of two years, changes in the right thumb nail were noted. Trauma to the thigh and to the nail prior to the onset of disease was denied. There was no history of skin disease in the parents or other relatives and examination of the mother and brother of the patient revealed no evidence of psoriasis.

When first seen by the author, a striking linear eruption was noted. This extended from the superior aspect of the right buttock, slightly to the right of its mid-line, down to the inferior aspect of the buttock, just to the left of the mid-line. It continued from a point on the posterior aspect of the right thigh, slightly below and to the left of where it had ended on the buttock and extended in a straight line inferiorly for a short distance; it then curved to the right, ending in the mid-line just above the popliteal space. The lesions consisted of erythematous, moderately elevated, flat-topped, scaly plaques which lacked any verrucous element. Scraping off the scales resulted in fine, pin-point bleeding. Depigmentation was noted around, as well as between, some of the plaques and the lower third of the linear eruption consisted of a narrow band of achromia with a few small, scaly, erythematous papules in the center of its upper part. Clinically, the lesions were typical of psoriasis, but the linear distribution and early onset suggested a psoriasiform linear nevus. Scaling of the scalp and other cutaneous lesions were absent. The nail plate of the right thumb was grayish in color, thickened, studded by many small pits and elevated at its free edge. Non-tender, puffy erythema of the perionychial tissue was also present. Repeated scrapings and cultures for fungi from the nail and surrounding skin gave negative results.

Histopathology.—A piece of tissue was excised



Fig. 1. Linear psoriasis. Characteristic erythematous, scaly, flat-topped plaques in linear arrangement.

from one of the plaques on the thigh and prepared for microscopic examination. The histologic structure was considered to be typical of psoriasis (fig. 2). Parakeratotic scale overlay an epidermis which was uniformly and regularly acanthotic. A few microabscesses (of Munro) were observed within and just below the corneous layer. Several of the downward-proliferating rete pegs had fused to form clubs. The suprapapillary plates were, for the most part, extremely thin. The papillary corium showed edema, dilated and rigid-appearing capillaries, and a moderate inflammatory infiltrate composed chiefly of lymphocytes.

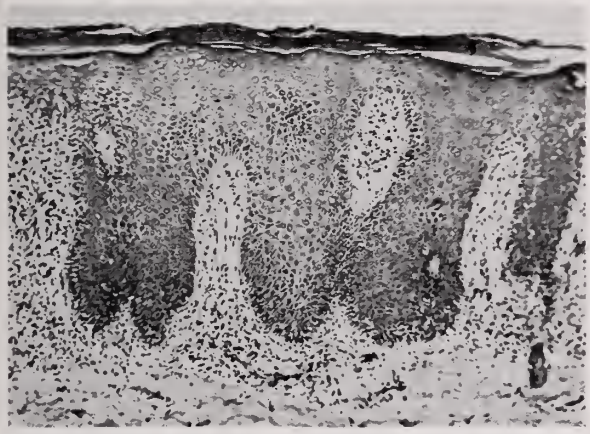


Fig. 2. Photomicrograph of section from an erythematous plaque on the thigh (hematoxylin and eosin; x 134).

Therapy.—Ointments of ammoniated mercury, tar, sulfur and salicylic acid and a solution of five per cent chyrsarobin in chloroform were employed, with little improvement. Solid carbon dioxide was applied to a few small areas and resulted in disappearance of the lesions treated. Unfortunately, the emotional instability of both patient and mother and the resultant anxiety induced in them by a blister-raising form of therapy, necessitated discontinuing this type of treatment. The right thumb was treated over a period of a few months with hot soaks. No improvement was noted and roentgen-ray therapy was finally instituted. Following two exposures of 100 r. unfiltered, at a two week interval, normal nail formation and disappearance of the surrounding erythema resulted. With the exception of a few pits in the nail plate, no recurrence was noted during the following three months.

During the total six month period of observation, the linear eruption extended inferiorly to below the popliteal space. At the time of writing, the lesions cover an area 30.6 cm long and 2.0 mm to 2.0 cm wide (fig. 1).

Comment

The typical histologic structure confirmed the diagnosis of linear psoriasis as opposed to psoriasiform linear nevus. It is believed that the dystrophic change of the right thumb was also psoriatic. The discoloration, thickening, pitting, elevation and lamination of the nail plate are all changes characteristically observed in psoriasis of the nails. Not quite so common, however, is the type of change in the skin around the nail such as was seen in this patient. That this may occur is mentioned by Crawford[4] in his comprehensive article on psoriasis of the nails. Patients presented with the diagnosis of psoriasis of the nails by Andrews[5] and by Cornell[6] showed the same alteration of the perionychial tissue as was observed in the case being reported.

MacKee and Cipollaro[7] state that psoriasis before the age of 5 years is uncommon, but that it has been noted in infants as early as the first few weeks of life. Senear[8] presented a 7 month old child with an eruption believed to be psoriasis. Eisenstadt, in discussion of Senear's case, states that psoriasis has been reported in a child of 6 weeks and that he had observed it in a 9 month old baby. Traub[9] presented a patient with psoriasis which had its onset at 18 months. Rille[10] reported on a 6 day old infant with the disease, while Neuman[11] and Kaposi[12] have each reported a patient in whom the dermatosis appeared before the age of one year. The cases just cited are exceedingly rare, however, for the disease most frequently has its onset in the second and third decades of life[13]. Madden[14], in a series of 44 patients, observed the youngest to be 4 years of age, the oldest 82, and an average age of onset of 26 years. Lane and Crawford[15], in their study of 232 cases of psoriasis, noted that the youngest and oldest patients were 6 and 82 years respectively and that the earliest age of onset was 2 years.

Summary

A patient with a linear eruption which appeared at the age of 6 months and which was histologically psoriasis is reported.

Although difficult to prove, it is believed that the dystrophic changes of the right thumb nail were on a psoriatic basis.

This case is unusual not only because of the rarity of linear psoriasis, but also because of its early age of onset.

Bibliography

[1]Fox, H.: In discussion on Fraser, F.: A Case for Diagnosis (Linear Nevus, Psoriasiform Type? Psoriasis with an Unusual Distribution?), Arch. Dermat. & Syph. 35:359 (Feb.) 1937.

[2]Fox, H.: In discussion on Clark, A. S.: Linear Psoriasis, Arch. Dermat. & Syph. 6:378 (Sept.) 1922.

continued on next page

ALLERGY MEETING

The 6th Annual Meeting of the American Academy of Allergy will be held March 6, 7 and 8 at Los Angeles. For detailed information write to the Secretary, 208 East Wisconsin Avenue, Milwaukee, Wisconsin. Rhode Island members of the Academy will be glad to sponsor local physicians for attendance at the meeting, and anyone interested is requested to communicate with the executive secretary at the Medical Library.

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[3]Woringer, F.: Psoriasis Zoniforme, Bull. Soc. Franc. de Dermat. et Syph. 43:851 (May) 1936.

[4]Crawford, G. M.: Psoriasis of the Nails, Arch. Dermat. & Syph. 38:583 (Oct.) 1938.

[5]Andrews, G. C.: Psoriasis of the Nails, Arch. Dermat. & Syph. 30:148 (July) 1934.

[6]Cornell, V. A. H.: Psoriasis? Arch. Dermat. & Syph. 31:903 (June) 1935.

[7]MacKee, G. M., and Cipollaro, A. C.: Skin Diseases in Children, ed. 2, New York, Paul B. Hoeber, Inc., 1947, p 172.

[8]Senear, F. E.: Psoriasis, Arch. Dermat. & Syph. 2:113 (July) 1920.

[9]Traub, E. F.: Psoriasis Beginning in Infancy, Arch. Dermat. & Syph. 53:209 (Feb.) 1946.

[10]Rille, cited by Ormsby and Montgomery (13), p 311.

[11]Neuman, cited by Ormsby and Montgomery, p 311.

[12]Kaposi, cited by Ormsby and Montgomery, p 311.

[13]Ormsby, O. S., and Montgomery, H.: Diseases of the Skin, ed. 7, Philadelphia, Lea and Febiger, 1948, p 311.

[14]Madden, J. F.: Psoriasis; A Clinical and Laboratory Statistical Study, Minnesota Med. 22:381 (June) 1939.

[15]Lane, C. G., and Crawford, G. M.: Psoriasis, A Statistical Study of Two Hundred and Thirty One Cases, Arch. Dermat. & Syph. 35:1051 (June) 1937.

PROVIDENCE MEDICAL ASSOCIATION—1949

concluded from page 73

for meetings for the association, I have been impressed by the interest of the doctors of this community in the social and economic aspects of medicine. No longer can we indulge in purely scientific programs. There is a demand from the rank and file to be informed fully about what is going on in social legislation as it affects the profession and the public in matters of health. The tremendous interest in the Blue-Cross Medical Society negotiation as evidenced by the calling of a *special meeting* to be informed and to discuss it, is plain evidence of this interest. The future officers of the association will, I know, recognize the fact as good and arrange to have speakers who will keep us all properly informed in such matters. Our society fortunately has one of the best informed executive secretaries in the country. We are living in a fast changing time. Old values are being replaced by new for good or bad. Let us be informed so that we may preserve and not lose the proven values of yesterday and yet be ready to accept the good in the new of today and of tomorrow. Let us be the informed leaders in these movements, guiding and directing as is our heritage in matters of health so that we may not be caught in an avalanche by misguided lay enthusiasts and find ourselves eventually the regimented slaves of the bureaucracy of a "welfare state," a tragedy for us, and for our patients.

With this message I now pass on the gavel after a most stimulating and valuable experience. My thanks to all who have contributed to our programs.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held on January 18, 1950

A REGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, January 18, 1950. The meeting was called to order by the President-elect, Dr. Charles J. Ashworth, who presided in the absence of Dr. Peter Pineo Chase, President, and Dr. Edgar S. Potter, Vice President. The following members were in attendance:

Kent County
Rocco Abbate, M.D.
Peter C. Erinakes, M.D.

Pawtucket Medical
Edward H. Trainor, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
Earl J. Mara, M.D.

Washington County
Louis Morrone, M.D.
Samuel Nathans, M.D.

Woonsocket County
George Keegan, M. D.
Joseph McKenna, M.D.

Bristol County
Ulysse Forget, M.D.
(Alternate Delegate)

Providence Medical
J. Murray Beardsley, M.D.
E. Victor Conrad, M.D.
Frank B. Cutts, M.D.
Donald DeNyse, M.D.
John Dillon, M.D.
William J. H. Fischer, M.D.
Peter F. Harrington, M.D.
William Horan, M.D.
Russell R. Hunt, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D.
Robert G. Murphy, M.D.
Joseph C. O'Connell, M.D.
Edwin B. O'Reilly, M.D.
George W. Waterman, M.D.
Michael J. O'Connor, M.D.

Officers
Charles J. Ashworth, M.D.
Morgan Cutts, M.D.

Also in attendance was Dr. Charles L. Farrell, Delegate to the American Medical Association, and Mr. John E. Farrell, Executive Secretary.

REPORT OF THE SECRETARY

Dr. Morgan Cutts, Secretary of the Society, submitted the following report:

Since the House of Delegates last met the Council of the Society has held two meetings to transact the business of the Society. Some of the work is summarized briefly as follows:

The Committee on Industrial Health was authorized to conduct a rehabilitation clinic, at a time and place to be decided by the committee, in conjunction with the R. I. Curative Center.

The President was authorized to name a special committee on the Medical Examiner Law to study and assist the Attorney General of the State.

The President was authorized to appoint a Medical-Dental Committee.

The President was authorized to name three delegates from the Society to the Council of the New England State Medical Societies.

It was voted that there should be a Committee on the revision of the By-Laws, to be named by the President.

It was voted to have representation at a hearing before the Committee on Corporations of the House of Representatives of the Rhode Island General Assembly relative to jury duty for physicians and surgeons.

The request from the Providence Medical Association that it discontinue its committee on air pollution abatement, and that a similar committee be established as a state society committee was adopted.

An advisory Committee on Nutrition was authorized.

The Chairman of the Committee on Public Relations, the Treasurer and the Executive Secretary were authorized as a committee to consider plans for a prize essay contest for high school students.

The Treasurer was authorized to invest $1,000 of the cash in the General Fund credited to the Davenport fund in U. S. Treasury bonds.

Drs. Charles J. Ashworth, and Charles L. Farrell, and the Executive Secretary, were named as delegates to the National Education Campaign meeting called by the AMA at Chicago for February 12, 1950.

Dr. Stanley Sprague, chairman of the Committee on Industrial Health was named as the Society's official delegate to the Congress on Industrial Health to be held in New York the week of February 20, 1950.

The report of the special committee on medical examiners was approved, together with the specific recommendations made in the report to the Attorney General of Rhode Island.

The Governor of the State was requested to consider official representation from the Rhode Island Medical Society on his committee to be named from Rhode Island to the MidCentury White House Conference on Children and Youth.

It was voted that the Treasurer bill the Fellows of the Society for the AMA dues at his convenience, and in such manner as he deems best.

continued on next page

It was moved that the report of the Secretary be accepted and placed on file. The motion was seconded and adopted.

Dr. Ashworth called to the attention of the House that the committee delegated to attend the National Education Campaign meeting in Chicago on February 12 would be reimbursed for its traveling expenses by the American Medical Association. He also noted that the expenses of the representative to the Industrial Health meeting would be paid by the Society.

Recommendations

The secretary read a communication from the Pawtucket Medical Association relative to possible changes in the recently enacted law regarding the position of Medical Examiner in the State of Rhode Island.

Dr. O'Connell reported briefly of the work of the subcommittee of the Council on the problem of the Medical Examiner in the State. He also reported on recent meetings with the Governor and with the Attorney General regarding the recommendations made by the committee to the Attorney General.

* * *

The Secretary read a communication from the headquarters of the National Education Campaign asking if the Rhode Island Medical Society had adopted any resolution against compulsory health insurance. The Secretary reported that the Society was not on record in this matter and he submitted the following resolution for consideration by the House of Delegates:

WHEREAS the medical profession in Rhode Island, and to our best knowledge throughout the country, has made available to the people the best medical care obtainable in the world, thereby helping these United States to become the healthiest nation, and

WHEREAS the experience of all countries where Government has assumed control of medical services has shown a progressive lessening of medical standards and medical care, as well as the destruction of the voluntary system, and

WHEREAS there is now great political pressure in this country to federalize medical care through a system of taxation that is not insurance for health and that will plunge this State and this country into greater debt without improving health care, and

WHEREAS the people of Rhode Island, and in increasing numbers throughout the country, have demonstrated strong support for voluntary programs for health care, Now therefore,

BE IT RESOLVED that the House of Delegates of the Rhode Island Medical Society hereby go on record against any form of compulsory taxation resulting in a so-called health insurance program, and against any system of political medicine designed for bureaucratic control.

Dr. Abbate moved that the House of Delegates adopt the resolution as read. The motion was seconded and unanimously voted.

Blue Cross Directors

The Secretary reported that the Council of the Society recommend the nomination of only two representatives from the Rhode Island Medical Society to the Board of Directors of the Hospital Service Corporation of Rhode Island to serve for the year 1950. He also reported that the Council placed in nomination Drs. Samuel Adelson, of Newport, and G. Raymond Fox, of Pawtucket.

Dr. Frank Cutts moved the approval of these nominations. The motion was seconded.

Dr. Ashworth briefly discussed the motion and explained to the House of Delegates that in 1946 the Society agreed to permit Blue Cross to be a Medical Service Corporation on certain conditions, one of which was that one director of every four of Blue Cross would at all times be a doctor of medicine nominated by the Society. In view of the fact that Blue Cross has never operated as a Medical Service Corporation as planned, and since the Society now has its own nonprofit corporation to carry out the proposals of the original legislation, the terms of the 1946 agreements with the Blue Cross are now considered as withdrawn.

Consequently, the Council did not feel that it should have seven directors, and since it was inviting Blue Cross to have two on the Board of Directors of Physicians Service, it seemed advisable to suggest two from the Society on the Blue Cross Board. If they desired only one instead of two, he expressed the opinion that they should be free to make the choice. The motion as made by Dr. Cutts was unanimously adopted.

Meeting Dates

The Secretary reported that the Council recommended to the House of Delegates the adoption of the date Wednesday, December 13 for the midwinter meeting of the Society to be held in Woonsocket, Rhode Island, and the dates of May 9 and 10, 1951, for the Annual Meeting to be held in Providence.

Dr. Kramer moved that the recommendations of the Council regarding the meeting dates be adopted. The motion was seconded and passed.

Report of the Delegate to the American Medical Association

Dr. Charles L. Farrell, Delegate, reported on the American Medical Association mid-year clinical meeting held in Washington, D. C., in December, 1949. He reviewed the highlights of the meeting of the House of Delegates of the American Medical Association and he discussed in some detail the reasons for the American Medical Association annual assessment. He also spoke briefly regarding health legislation before Congress and cited the objection of the medical profession to H 6000 and

S 1411. It was moved that the report of the delegate to the American Medical Association be accepted as presented. The motion was seconded and passed.

Report of Physicians Service

Dr. Joseph C. O'Connell, President of the Rhode Island Medical Society Physicians Service, gave a résumé report of the development and progress of that corporation. This report is made a part of the official minutes of the meeting.

Dr. Frank Cutts moved that the report submitted by Dr. O'Connell be accepted and placed on file. The motion was seconded and passed.

Nominations to Physicians Service

Dr. Ashworth called to the attention of the House that the By-Laws for the Rhode Island Medical Society Physicians Service provided that twelve Fellows should be nominated by the House of Delegates.

Dr. Frank Cutts stated that careful consideration should be given the nominees for this important work and in addition to the men serving as directors and recommended by the President of Physicians Service in his report, he offered as nominees the following:

Irving Beck, M.D.
Kenneth Burton, M.D.
Wilfred Carney, M.D.
Marshall Fulton, M.D.

Dr. Peter F. Harrington placed in nomination Dr. Earl Mara.

Dr. John Dillon placed in nomination Dr. Daniel V. Troppoli, Dr. Henry Joyce and Dr. Robert G. Murphy.

Dr. William J. H. Fischer placed in nomination Drs. Herman Lawson, Lawrence Martineau, George Young, and David Freedman.

Dr. Ashworth called attention to the fact that the importance of the work of Physicians Service warranted careful attention by the House of Delegates in nominating men who were familiar with the work to be undertaken, and he stated that he considered the list of nominations to include those suggested in the report submitted by Dr. O'Connell. There was brief discussion after which Dr. Frank Cutts moved that the twelve physicians suggested in the report submitted to the House by the president of Rhode Island Medical Society Physicians Service be included as nominees. The motion was seconded and adopted.

Dr. Frank Cutts moved that the four nominees receiving the most votes should serve the three year terms, the four receiving the next highest number of votes the two year terms, and the four receiving the next highest votes the one year terms, and in case of a tie vote that the presiding officer shall resolve the tie, and that the twelve nominees voted by the Delegates shall be submitted to Physicians Service as nominees to its Board of Directors from the Rhode Island Medical Society.

The motion was seconded and adopted.

Dr. Robert G. Murphy requested that his name be withdrawn from the list of nominees. Dr. Mara moved that the ballot be signed at the will of the Delegate casting the ballot. The motion was seconded and passed.

Dr. Morgan Cutts read the complete list of nominees as follows, and requested that members of the House mark on a written ballot twelve choices.

Joseph C. O'Connell, M.D.	Irving Beck, M.D.
Rocco Abbate, M.D.	Kenneth Burton, M.D.
Charles J. Ashworth, M.D.	Wilfred Carney, M.D.
Morgan Cutts, M.D.	Marshall Fulton, M.D.
Charles L. Farrell, M.D.	Earl Mara, M.D.
Louis Cerrito, M.D.	Daniel V. Troppoli, M.D.
Louis Burns, M.D.	Henry Joyce, M.D.
Henri Gauthier, M.D.	Herman A. Lawson, M.D.
Albert H. Jackvony, M.D.	Lawrence Martineau, M.D.
Frank B. Cutts, M.D.	George Young, M.D.
Orland Smith, M.D.	David Freedman, M.D.
Charles E. Millard, M.D.	

Dr. Ashworth named Dr. Louis Kramer and Dr. William J. H. Fischer to serve as tellers and to record the vote with the assistance of the Secretary.

* * *

The Secretary subsequently reported that the following were the twelve receiving the nominations from the House of Delegates.

Charles J. Ashworth, M.D.
Joseph C. O'Connell, M.D.
Morgan Cutts, M.D.
Albert H. Jackvony, M.D.
Charles L. Farrell, M.D.
Henri Gauthier, M.D.
Louis Burns, M.D.
Louis Cerrito, M.D.
Rocco Abbate, M.D.
Frank Cutts, M.D.
Orland Smith, M.D.
Earl Mara, M.D.

Jury Duty for Physicians

Dr. Ashworth reported on the representation he had made for the Society this day at the meeting of the House Committee on Corporations of the Rhode Island General Assembly regarding jury duty for physicians and surgeons. He read the statement that he had submitted to the committee and to the press and he explained that it was based on the opinions of the members of the Council.

Dr. Harrington commended Dr. Ashworth for the excellent statement issued by the Society on this matter.

* * *

The meeting adjourned at 10:06 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*

The RHODE ISLAND MEDICAL JOURNAL

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JURY DUTY

The recent publicity by one of our newspapers of the many exemptions provided under the statutes whereby citizens may be eliminated from serving as jurors has focussed attention on the inclusion of physicians and surgeons among the exemptions. To our best knowledge physicians have never sought that exemption for any personal reason. That the General Assembly saw fit to exempt doctors from jury duty is certainly justified in view of the demand upon their time, a demand that cannot be circumscribed by any legislative rules or regulations if the sick are to be attended.

As citizens the physicians of this State contribute more than their fair share to community responsibilities. There is no group in the State that gives more freely of its time to planning and aiding all phases of civic activity to make for a better way of life for everyone. We are sure that if physicians are needed for jury duty they will accept that assignment. But when one reads the lengthy list of exemptions from jury service the thought must readily come to mind that physicians and surgeons, of all listed, have far greater reason for being in the classification than the majority.

The position of the medical profession of Rhode Island was admirably set forth at a hearing before the House committee on corporations of the General Assembly last month by Dr. Charles J. Ashworth, president-elect of the Rhode Island Medical Society. We commend his statement which follows for reading by every Fellow of the Society:

"To our knowledge neither the Rhode Island Medical Society, nor its members individually, have ever asked for exemption from jury duty. We had no part in writing the legislation now on the statute books whereby certain persons, including physicians, shall be exempt from jury duty.

The physicians and surgeons of Rhode Island have always been ready and willing to discharge their obligations and duties as citizens. Our record as a group is evidence of our acceptance of civic responsibilities as I am sure you and all the people of the State must know. Physicians give liberally of their free time to serve the many municipal and state organizations and agencies in all phases of community life. We are always ready, as every citizen should be, to discharge duties necessary for good government and effective justice in our courts.

Therefore, we can only conclude that if the General Assembly of this State thinks that physicians and surgeons should not be exempt from jury duty, and if the public is agreeable to any inconveniences that might result because a physician is removed from active practice by jury service, we certainly have no objection to such a provision in the law.

We have noted the many groups now exempt from jury service, and we infer that the General Assembly must have had good reason for providing such exemptions. We infer that physicians and surgeons have been exempt because it is well-known to all that sickness is not predictable, and therefore a physician is at the service of his patients at all

times. It is true that if the physician were on jury duty he could possibly refer his patients to another physician, just as he would if he were ill or out of the state. But whether the patients would wish such an arrangement when their family doctor could be available is apparently a situation that must have concerned the General Assembly when it drafted the exemption of physicians.

We have inferred that our exemption was granted without our asking for it because the General Assembly felt that we probably render a greater human service by being free to attend the sick as they may need us than we would serve the community and justice by taking a place in the jury box.

We have inferred that the General Assembly felt that a physician's place on the jury could be filled equally well by another citizen, but a physician's place at the bedside of a sick patient cannot be filled except by another physician.

We, therefore, as citizens ask no exemption from jury duty. That we may be exempted as physicians and surgeons to be free at all times to carry on our task of serving the sick, and the well, is a matter the General Assembly and the public may well determine."

OFF TO A GOOD START

The first annual meeting of the corporation of our Rhode Island Medical Society Physicians Service presented one of the most favorable reports possible for a new organization recounting its first year's achievement, or more specifically in this instance, its first few months of operation.

The clearance of multitudinous details, the willing service of members of the Society to work on various committees, and particularly the Joint Operations Committee assigned the task of meeting almost weekly to iron out the problems involving sales of the policy, indicate a bright future for our own surgical plan. By mid-January 5,244 contracts had been sold to provide surgical-medical coverage for 11,771 persons; the number of participating physicians was reported as 458, with the number increasing daily.

Off to a good start, the Corporation completed the complement of medical representation on the board of directors by electing Drs. Joseph C. O'Connell, Charles J. Ashworth, Morgan Cutts, Albert H. Jackvony, Orland Smith and Frank Cutts, all of Providence, Dr. Charles L. Farrell of Pawtucket, Dr. Henri Gauthier of Woonsocket, Dr. Louis E. Burns of Newport, Dr. Louis Cerrito of Westerly, Dr. Earl Mara of Pawtucket, and Dr. Rocco Abbate of Warwick, thus providing for statewide representation.

The directors in turn re-elected the officers who have served the corporation since its start in 1949, Dr. O'Connell as president, Dr. Abbate as vice president, Dr. M. Cutts as secretary, and Dr. Ashworth as treasurer.

The program is off to a good start in the capable hands of the elected directors. With the assistance of the Hospital Service Corporation, it should enjoy a very successful year.

MEDICAL EDUCATION

The recent criticisms stemming from statements reportedly made at the American Conference of Academic Deans held in Cincinnati last month regarding medical education warrants a strong answer from the medical profession of this country. The inference left with the public that the medical profession and the medical schools are in collusion to protect physicians from the competition of outsiders by keeping down the number of new students through strict admission limitations borders on the ridiculous.

Applications for admission to the 5,864 openings in the freshman classes of seventy of the nation's medical colleges totaled 88,810 in 1949, according to a survey made by William S. Guthrie, junior dean of Ohio State University College of Arts and Sciences, and reported in *Higher Education* last September. This was a ratio of over fifteen applicants for each opening, but it must be remembered that today most applicants apply to more than one medical school, and some apply to as many as twenty-five or thirty.

The process of selection is just that, not one of exclusion. The careful selection of students for the study of medicine has to be done with keen recognition that medical education is the foundation of our national health and welfare. Additional factors that curtail enrollment are the capacity of the physical plant of the individual medical school, the number of qualified teachers available to instruct the students, and the number of hospital beds available for clinical instruction. Adequate equipment must be had, students can't teach one another, nor can they learn from books alone.

All these factors necessarily curtail medical school enrollment, and yet the medical schools at this time are training students at the limit of their capacity with 6,887 freshmen currently on the rosters, an increase of 373 over last year.

Educators are the first to admit that accelerated programs such as were maintained during the war tend to lower the standard of performance of the medical schools. It is true that if we disregarded the necessity of adequate facilities and teachers we could greatly increase the number of students. But how many people would consult of their own accord such inadequately trained physicians once they were returned to the communities of the country to practice?

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During the past twenty years the number of physicians in this country has increased at a greater rate than the population as a whole. From an estimated total of 152,000 in 1929 the number had expanded by 1940 to in excess of 175,000. Preliminary data for 1949 indicate that there are now more than 200,000 physicians in the continental United States.

In the past eight years new medical schools or expansions of former 2-year schools of basic medical sciences have been developed in Alabama, California, Illinois, North Carolina, Texas, Utah, and Washington, and others are being considered in Mississippi, Florida, West Virginia, and elsewhere. We know that there has been agitation in Connecticut for a medical school at the State University at Storrs. The medical profession of Maine has been the staunchest support for a medical school in that State. And we feel certain that if Rhode Island ever decides that it can appropriate the great financial outlay to start a medical school here, the physicians of Rhode Island will be foremost among those urging development of adequate facilities for more students of medicine.

THE PHYSICIAN'S SECRETARY

In many states there are organized associations of medical secretaries. Perhaps we should have one in Rhode Island. Certainly it would be well if every physician having an office secretary, or nurse, who handles his telephone calls, meets his patients and makes appointments for them, and who in general shares the responsibility for the successful operation of the office, took time regularly to evaluate her work.

Criticisms often come to the medical society of ill considered and even discourteous treatment from secretaries. Particularly is this true of telephone calls. The impressions that the patient receives are too often used as the false premiss for a conclusion about physicians in general. Thus, not alone is the individual physician injured; the whole profession has another black mark that even professional public relations counsel can't eradicate.

That the services of a capable and efficient secretary are invaluable to the busy physician goes unchallenged. That the majority of the medical secretaries are conscious of the role they play in the professional life of the physician is also admitted. But that there must be continual vigilance and progressive training in the techniques of meeting the public satisfactorily is equally true.

ATTACK ON ARTHRITIS

Rhode Island became the sixteenth state to form a chapter of the Arthritis and Rheumatism Foundation when more than two dozen professional and civic leaders, headed by Governor John O. Pastore, met at the medical library last month. The purpose of the Foundation is to bring together and to unify the many appeals by various groups eager to attack this health problem.

The founders' group adopted a constitution and by-laws, and then elected Mr. William J. Halloran, president of the trucking concern of the same name, as its first president. Heading the medical committee of the local chapter is Dr. William J. O'Connell, director of the arthritis clinic at St. Joseph's hospital, where a small amount of the drug cortisone has been received for applied research.

The crippling effects of arthritis and rheumatism are all too well-known to the physician. The public, too, is extremely conscious of this disabling illness, and the development of the new state organization to assist in raising funds for research and new controls of the disease is certain to win popular support.

MORE AFRAID OF LIFE

"Too many people are asking the federal government to perform the functions of state governments. Too many people want to lean upon the government, forgetting that the government must lean upon the people. Too many people are thinking of security instead of opportunity. They seem more afraid of life than of death.

"...We must emphasize the freedom of the individual who by his initiative has made America prosperous. And we cannot very well boast of freedom under the American system if we are going to change that system and force the people to surrender more liberties to a centralized government.

"When we see the states of Western Europe and Great Britain, which have embraced socialism, unable to stand on their own feet and the very existence of their governments depend upon the tax payers of the United States, it would seem prudent for us to hold fast to our system of government that has proved efficient in war and in peace, and put our financial house in order ..."

... HON. JAMES F. BYRNES, *former Supreme Court Justice, Cabinet Member and Senator,* before the Conference of Governors in Biloxi, Mississippi, Nov. 21, 1949.

WORKMEN'S COMPENSATION REPORTS

The attention of Fellows of the Society is directed to the amendment to the state workmen's compensation law, enacted last year, which provides in part as follows:

"...The employee shall be entitled to a full, exact, signed duplicate copy of the medical report of the examining physician, which shall be mailed by the examining physician to the employee or his attorney at the same time the original report is sent to the employer or carrier..."

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RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Report of First Annual Meeting of Corporation Held at Providence, January 18, 1950

THE FIRST annual meeting of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Rhode Island Medical Society Library on Wednesday, January 18, 1950. The meeting was called to order by the President, Dr. Joseph C. O'Connell, at 10:10 p.m.

The following members of the Corporation were in attendance:

Members of the House of Delegates of the Rhode Island Medical Society

Kent County
Rocco Abbate, M.D.
Peter C. Erinakes, M. D.

Pawtucket Medical
Edward H. Trainor, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
Earl J. Mara, M.D.

Washington County
Louis Morrone, M.D.
Samuel Nathans, M.D.

Woonsocket County
George Keegan, M. D.
Joseph McKenna, M.D.

Bristol County
Ulysse Forget, M.D.
(Alternate Delegate)

Providence Medical
J. Murray Beardsley, M.D.
E. Victor Conrad, M.D.
Frank B. Cutts, M.D.
Donald DeNyse, M.D.
John Dillon, M.D.
William J. H. Fischer, M.D.
Peter F. Harrington, M.D.
William Horan, M.D.
Russell R. Hunt, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D
Robert G. Murphy, M.D.
Joseph C. O'Connell, M.D.
Edwin B. O'Reilly, M.D.
George W. Waterman, M.D.
Michael J. O'Connor, M.D.

Officers
Charles J. Ashworth, M.D.
Morgan Cutts, M. D.

Directors of Physicians Service (Not members of the House of Delegates)

Charles L. Farrell, M.D.
Henri Gauthier, M.D.
Louis Cerrito, M.D.
Albert H. Jackvony, M.D.

Also in attendance was Mr. John E. Farrell, Executive Secretary.

Report of the Secretary

Dr. Morgan Cutts, Secretary of the Corporation, submitted his annual report as follows:

The Rhode Island Medical Society Physicians Service was incorporated on May 3, 1949, for the purpose of adopting the provisions of Chapter 1598 of the Public Laws of Rhode Island, said corporation to be administered by the Rhode Island Medical Society for the purpose of increasing the extent to which voluntary insurance against the cost of medical care is made available to the people of the State of Rhode Island.

An organization meeting of the corporation was held at the Rhode Island Medical Society Library on May 17, 1949, at which the following were elected as officers:

JOSEPH C. O'CONNELL, M.D., *President*
ROCCO ABBATE, M.D., *Vice President*
MORGAN CUTTS, M.D., *Secretary*
CHARLES J. ASHWORTH, M.D., *Treasurer*

At this meeting a motion was adopted that a committee on by-laws be appointed, and that legal advice be sought as regards the liability of the incorporators and ways to eliminate such liability.

In September the Corporation, through its President, reported to the House of Delegates of the Rhode Island Medical Society regarding its actions. Recommendations were also made which were adopted by the House of Delegates to authorize Physicians Service to continue its negotiations with the Hospital Service Corporation (Blue Cross) of Rhode Island relative to their cooperation in the business phases of Physicians Service. Subsequently these negotiations were completed, and a joint operations agreement signed.

On November 8, 1949 the board of directors of Physicians Service met and adopted the by-Laws as submitted by its committee which had drafted them with advice of legal counsel.

The Board elected as additional directors the following: Henri Gauthier, M.D., of Woonsocket, Louis E. Burns, M.D., of Newport, Louis Cerrito, M.D., of Westerly, and Albert H. Jackvony, M.D., of Providence.

Named to serve on the Joint Operations Committee with the Blue Cross representatives were Drs. Charles J. Ashworth, Charles L. Farrell, and Albert H. Jackvony.

The Board of Directors met again on November 17, 1949, and at this meeting the following actions were taken:

1. The subscribers contract was approved for submission to the State Insurance Commissioner.
2. A brochure for mailing to the Fellows of the Society, as well as non-members, was submitted and approved.

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PHYSICIANS SERVICE MEETING

continued from page 84

3. An official seal was adopted for the Corporation.
4. The question of Blue Shield membership was tabled after discussion of the proposal.
5. The original by-laws were amended to provide for a total of 18 on the board of directors.
6. An Executive Committee, a Finance Committee, and a Professional Advisory Committee were established.
7. The Board voted to retain Mr. William E. McCabe, as legal counsel for the Corporation.
8. The Board voted to engage Mr. John E. Farrell as its executive secretary.

A meeting of the Board of Directors was held at the Rhode Island Medical Library on December 13, 1949. At this meeting there was lengthy discussion regarding liberalizing the Rhode Island Plan, and it was agreed to ask the Health Insurance Committee of the Society to consider such action, and to ask the various participating companies to accept such a proposal.

A meeting of the board of directors was held at the Rhode Island Medical Library on Monday, January 16, 1950. At this meeting it was moved that the present nine members of the board of directors, and three additional nominees be suggested to the House of Delegates for its consideration. The additional nominees were Dr. Frank B. Cutts, Dr. Charles Millard of Warren, and Dr. Orland Smith.

The Board voted that a fee of $10 be included in the master schedule of indemnities for nerve block with anesthetic agent, with a limit of three anesthetic blocks within a 90-day period, and that a fee of $15 be included in the master schedule of indemnities for nerve block with alcohol.

It was voted that checks of Physicians Service for amounts below $100 could be signed by the following designated assistant treasurers for that purpose alone: Dr. Morgan Cutts, Dr. Charles L. Farrell, and John E. Farrell. It was voted that payments over $100 shall be countersigned by the President of the Corporation, or any other officer.

The Board voted to pay the indebtedness already incurred, and the existing accounts due, as soon as funds are available.

It was voted to table for the present the question of membership in the national Blue Shield organization.

It was voted that participating physicians be informed that they need only to put a plus (+) sign as an answer to the question on the surgical medical report requesting information on the fee charged in excess of the indemnity allowed a patient above the income limits.

It was moved that the annual report of the Secretary be accepted and placed on file. The motion was seconded and adopted.

Annual Report of the Treasurer

Dr. Charles J. Ashworth, Treasurer of the Corporation, submitted a financial report for 1949 as follows:

Expenses paid in 1949 by the Rhode Island Medical Society:

Printing and postage	$ 147.78	
Payment to Blue Cross	$2,000.00	
		$2,147.78
Accounts outstanding:		
Edwards & Angell, Legal counsel	$869.70	
Printing (W. R. Brown Company)	$280.60	
Biennial report to State	$ 2.00	
		$1,152.30

He also reported that the premiums already received from the initial subscribers to Physicians Service exceeded $8,000.00, a sum sufficient to meet current expenses.

It was moved that the report be accepted and placed on file. The motion was seconded and adopted.

Recommendation to Board of Directors

Dr. Earl Mara of Pawtucket briefly discussed the By-Laws of the Corporation, and he moved that the Corporation recommend to the Board of Direc-

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tors that they consider an amendment to Sub Section D of Section 1 of Article 1 of the By-Laws that it may read

"Such other persons, non-physicians, as may be elected—" (The underscored words represent the change in the By-Laws suggested.)

Election of Board of Directors

The Secretary reported that the House of Delegates of the Rhode Island Medical Society in accordance with the By-Laws of the Corporation of Physicians Service, had submitted the names of twelve Fellows of the Society as nominees to the Board of Directors of Physicians Service as follows:

To be elected for three years—
Charles J. Ashworth, M.D.
Joseph C. O'Connell, M.D.
Morgan Cutts, M.D.
Albert H. Jackvony, M.D.

To be elected for two years—
Charles L. Farrell, M.D.
Henri Gauthier, M.D.
Louis E. Burns, M.D.
Louis Cerrito, M.D.

To be elected for one year—
Rocco Abbate, M.D.
Frank Cutts, M.D.
Orland Smith, M.D.
Earl J. Mara, M.D.

It was moved that the nominees submitted by the House of Delegates of the Rhode Island Medical Society be elected for the terms specified in the nominations. The motion was seconded and unanimously adopted.

The meeting adjourned at 10:25 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*

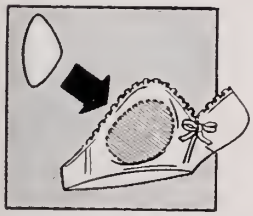


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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The 103rd Annual Meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 9, 1950. The meeting was called to order by Dr. George W. Waterman, President, at 8:35 p.m.

With the consent of the members, the Secretary was excused from the reading of the records of the previous meeting. Dr. Daniel V. Troppoli, Secretary of the Association, read his annual report for the year 1949. It was moved, seconded, and adopted that the report be received and placed on file.

Dr. J. Murray Beardsley, Treasurer of the Association, presented his annual report for the year 1949. It was moved, seconded and adopted that the report be received and placed on file.

The Secretary reported for the Executive Committee as follows:

1. At a recent meeting the Executive Committee of the Association voted to continue the Prize Case Report Contest in 1950, requesting that the committee in charge give the contest wider publicity, and that presentations of reports be made at the regular meetings of the Association during the year.

2. The proposal for a Committee on Hospitals and Professional Relations was carefully considered, and the recommendations for such a committee as advanced in the report of the Board of Trustees of the American Medical Association reviewed. The Committee is of the opinion that there is no need for such a committee for this Association and it recommends that none be appointed.

3. The President was authorized to appoint a program committee to plan the scientific meetings of the Association during the year.

The Presidential Address was then delivered by Dr. George W. Waterman, in which he reviewed the activities of the Association during the past year and indicated possible programs that might be attempted in the future.

The Secretary read the proposed slate of officers submitted by the Executive Committee to serve the Association in 1950.

The proposed slate was as follows:

President—Ubaldo E. Zambarano, M.D.
Vice President—Frank W. Dimmitt, M.D.
Secretary—Daniel V. Troppoli, M.D.
Treasurer—J. Murray Beardsley, M.D.
Trustee (1 year) Herbert E. Harris, M.D.
Executive Committee (4 members for 3 year terms) George W. Waterman, M.D.; William A. Horan, M.D.; Francis Chafee, M.D.; Michael J .O'Connor, M.D.
(1 member for 2 year term) Alfred L. Potter, M.D.

Delegates:

Robert Baldridge, M.D.	Russell Hunt, M.D.
J. Murray Beardsley, M.D.	Louis I. Kramer, M.D.
Peter Pineo Chase, M.D.	Herman A. Lawson, M.D.
E. Victor Conrad, M.D.	Edward McLaughlin, M.D.
Frank B. Cutts, M.D.	Robert Murphy, M.D.
William P. Davis, M.D.	John C. Myrick, M.D.
Donald DeNyse, M.D.	Joseph C. O'Connell, M.D.
John Dillon, M.D.	Michael O'Connor, M.D.
William J. H. Fisher, M.D.	Edwin B. O'Reilly, M.D.
David Freedman, M.D.	Alfred L. Potter, M.D.
Herman Grossman, M.D.	Louis Sage, M.D.
Peter Harrington, M.D.	Daniel V. Troppoli, M.D.
William Horan, M.D.	George W. Waterman, M.D.

The Secretary reported that he had received no counter nominations to the proposed slate of officers, and, therefore, he moved that it be adopted. The motion was seconded and adopted.

Dr. Waterman expressed regret that Dr. Ubaldo E. Zambarano, the new President, was ill and was unable to attend the meeting. He called upon Drs. Marshall Fulton and Harold Williams to serve as a Committee to escort Dr. Frank W. Dimmitt, newly elected Vice President, to the rostrum.

Dr. Dimmitt expressed the thanks for Dr. Zambarano, as well as his own appreciation, for the honors bestowed upon them by the members of the Providence Medical Association. He then presented to the retiring president, Dr. George W. Waterman, an engraved gavel as a gift from the members of the Association.

The Secretary reported the receipt of the communications from the Community Workshops, Inc. and the Providence Veterans Hospital, announcing the meetings to be held during the month, to which members of the Providence Medical Association were invited.

The President announced that the annual reports of the committees as submitted in writing by the various chairmen would be published in the Rhode

continued on page 90



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Bibliography:

1. Alyea, E. P., and Parrish, A. A.: South. M. J. *36*:719, 1943.
2. Nesbit, R. M., and Glickman, S. I.: J. Michigan M. Soc. *46*:664, 1947.
3. Lehr, D.: J. Urol. *54*:87, 1945.
4. Joelson, J. J.: J.A.M.A. *129*:157, 1945.
5. Kearns, W. M., in discussion on Herrold, R. D.: Wisconsin M. J. *41*:467, 1942.

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 88

Island Medical Journal; however, he invited any chairman who wished to report orally to do so.

Dr. Edward S. Cameron, Chairman of the Air Pollution Abatement Committee, read the report of his Committee, in which it was recommended that the Providence Medical Association Committee be terminated and that a new Rhode Island Medical Society Committee for Air Pollution Abatement be established. He moved that this recommendation be referred to the Council of the Rhode Island Medical Society for its consideration. The motion was seconded and adopted.

The Secretary reported that the Executive Committee recommends for election to active membership Dr. Arthur B. Kern of Providence. It was moved, seconded, and unanimously passed that Dr. Kern be elected to membership.

The Secretary reported as follows:

The Executive Committee has received and approved the budget proposed by the Treasurer for the Association for 1950, including the usual appropriations and allocations, totalling $7,775, and it now recommends to the Association that the Annual dues for 1950 for active members be, as in the past, $15, and the dues for Associate members be $5.



U. E. ZAMBARANO, M.D.
President, 1950
THE PROVIDENCE MEDICAL ASSOCIATION

A motion was made, seconded, and unanimously adopted that the proposed budget of the Treasurer be accepted and that the dues for the members of the Association for 1950 be $15 for active membership and $5 for Associate membership.

Dr. Waterman introduced as the first guest speaker of the evening, Mr. Nord Kitchen, representing the Providence Junior Chamber of Commerce, who spoke on "THE HOOVER REPORT."

In July 1947, Congress created the Hoover Commission which was given authority to point out areas for improved economy and efficiency in existing organizations, and also to recommend abolishing services not necessary to the efficient conduct of government.

This commission contained twelve men, half democratic and half republican, equally persons in the government and out of it. Our only living ex-president Mr. Hoover was made chairman. This commission created task forces comprising three hundred persons, including former cabinet officers, senators, governors of states, university professors, and business executives. These men worked fourteen months and brought back the most comprehensive study of government in all history. They found good work done by thousands of civil servants in dozens of departments. They also found that endless confusion then resulted from the growth of government. They found enormous waste of money and sinful waste of human effort.

Mr. Hoover estimated that application of the recommendations of the commission would save the nation at least three billion dollars a year.

An example of this lies in the fact that the supply department of one executive agency distributed about $34,000 worth of stock to its offices. Distribution costs $22,000. In other words, a $1.00 item cost the taxpayer $1.84 by the time it reached the ultimate consumer.

Important recommendations were also made in budgeting and accounting.

Mr. Kitchen urged all-round support of "The Hoover Report."

The second guest speaker was Dr. Joseph C. O'Connell, President of the Rhode Island Medical Society Physicians Service, who discussed the new nonprofit surgical-medical insurance program of the Society.

Dr. O'Connell stated that Dr. Abbate's committee did good work to help us accomplish the agreement with the Blue Cross. While it is a compromise, it protects our interests. Already three hundred physicians have enrolled. He urged the Providence Medical Association to get all its members to enroll. The Rhode Island Medical Society Physicians

continued on page 92



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PROVIDENCE MEDICAL ASSOCIATION

concluded from page 90

Service is now working under the board until the first annual meeting.

The Board of Directors is to be the House of Delegates. All of us owe a debt to Drs. Ashworth, Jackvony, and Farrell, who meet weekly and give their time to this corporation.

A question period then followed concerning some of the details of the functions of the plan.

The meeting adjourned at 10:20 p.m.

Attendance was 88.

Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.

BRISTOL COUNTY MEDICAL ASSOCIATION

The Bristol County Medical Association met Tuesday, January 17, 1950 at 9 P. M. at the Martin Memorial Home in Warren, R. I.

The minutes of the December meeting were read and approved.

Dr. U. Forget was named as an alternate to the House of Delegates for January 18, 1950.

Dr. Bruno reported from the council on the subject of "Jury duty for physicians."

A motion was made and approved that a special meeting be called with Mr. Sheldon and Mr. Munroe, directors of the Warren Industrial Trust Co., for the purpose of discussing the possibility of a Bristol County Hospital.

The speaker of the evening, Dr. Vincent Oddo presented his findings in the following cases of Asymptomatic Haematuria:

1. Female age 30 showed blood in the urine on two occasions, four months previous to her visit to the doctor, and at the time of her visit. Intravenous pyelograms revealed malignancy of one kidney. The differential point of diagnosis was the "CONVEX" appearance of the calices instead of the usual, normal "CONCAVE". Pathological examination after removal showed multiple papilomata of the pelvis and calices.

2. Woman of 55 had mass in left upper quadrant. No pain. She was surprised to see blood in her urine. X-ray showed *Hypernephroma* pressing on the kidney so as to obliterate it, and pushed the kidney down below its usual position in relation to the vertebrae and the level of the right kidney.

3. Woman 70, on cystoscopic examination showed papiloma of urethra. This was removed by cautery.

4. Recurrent calculus in urinary bladder. This calculus was so fragile that it crumbled when touched by cystoscope and was washed out.

A general discussion followed with a period of questions and answers.

Refreshments were served at the close of the meeting.

Meeting adjourned at 11:30 P. M.

Respectfully submitted,

ARCADIE GIURA, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held on December 15, 1949 at 12:00 noon in the Nurses' Auditorium of Memorial Hospital. Eight members, forming a quorum, were present.

As there were no communications and no new business the meeting adjourned until 6:30 P. M. the same day at the Pawtucket Golf Club for the annual Christmas Party.

Twenty-seven members attended, each bringing a small gift of value not less than $2.00 according to the suggestion of the committee, Dr. Tetreault and Dr. Woodcome.

Dr. Earl Kelley presided as Master of Ceremonies. There was no entertainment but the spirit of the season and good-fellowship made it unnecessary as Dr. Kelley pointed out.

The party adjourned on a motion by the President, Dr. John Gordon, at 10:00 P. M.

Respectfully submitted,

K. W. HENNESSEY, M.D., *Secretary*

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Raymond F. Hacking, M.D.
William A. Horan, M.D.
Louis A. Sage, M.D.
Edwin B. Gammell, M.D.
Catherine Zouraboff, M.D.
William P. Shields, M.D.

Committee on Entertainment
William J. H. Fischer, M.D., *Chairman*
Nathan A. Bolotow, M.D.
Herman P. Grossman, M.D.
Ralph DiLeone, M.D.
Harry E. Darrah, M.D.

Committee on Ethics and Deportment
John G. Walsh, M.D., *Chairman*
Robert H. Whitmarsh, M.D.
Marshall Fulton, M.D.
E. Victor Conrad, M.D.
Michael J. O'Connor, M.D.
Laurence A. Martineau, M.D.
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William Fain, M.D.

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Reuben C. Bates, M.D.
John Langdon, M.D.
Henry E. Utter, M.D.
D. William Bell, M.D.
Thomas J. Dolan, M.D.
Harold Calder, M.D.
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Florence M. Ross, M.D.
James P. Deery, M.D.
Frank A. Merlino, M.D.
J. Murray Beardsley, M.D.

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Frank B. Cutts, M.D.
Frederick Burns, M. D.
Louis I. Kramer, M.D.
Robert H. Whitmarsh, M.D.
Robert Baldridge, M.D.
Michael DiMaio, M.D.

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Emanuel Benjamin, M.D.
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E. Victor Conrad, M.D.
Nathan Rakatansky, M.D.
Henry S. Joyce, M.D.
J. Murray Beardsley, M.D.

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Ubaldo E. Zambarano, M.D., *Chairman*
George W. Waterman, M.D.
Frank W. Dimmitt, M.D.
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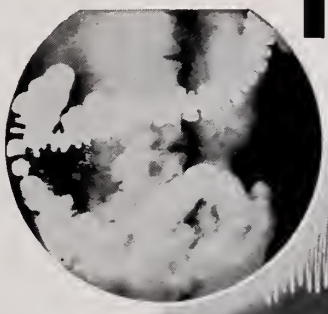
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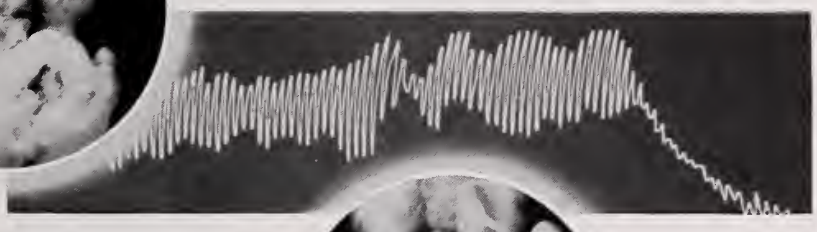
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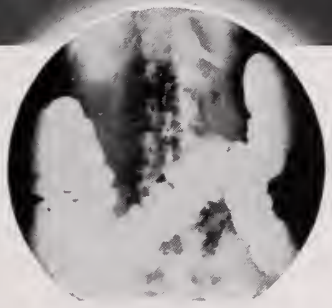
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ANNUAL REPORTS — 1949

THE PROVIDENCE MEDICAL ASSOCIATION

ANNUAL REPORT OF THE SECRETARY

The Association has enjoyed a very active and successful year. Its many committees have worked effectively in the interests of the membership and the public in general. We have witnessed the establishment under the auspices of the Association of an excellently-operated Medical Bureau to provide 24 hour telephone secretarial service. This new Bureau, started on September 1, has already demonstrated its great value to the physicians, and also to the public. Emergency medical calls have been handled through the Bureau as a public service.

During the year a group health and accident insurance policy was approved by the Association's committee and subsequently adopted by the membership with approximately 300 physicians now enrolled.

Seven meetings were held directly under the auspices of the Association, and in addition two joint meetings were held with the Rhode Island Medical Society, one at the Naval Air Station at Quonset in February, and the other at Newport in December. A special meeting was held on September 27 to discuss the new surgical-medical insurance plan adopted by the Rhode Island Medical Society. This program, patterned after similar ones operating successfully in other states, has been developed in great measure through the efforts of members of this Association who have served on committees of the State Medical Society.

A most successful annual dinner and golf tournament was held in September at the Ledgemont Country Club in Seekonk, for which the Committee on Entertainment is to be particularly commended.

The average attendance at meetings of the Association in 1949 was 90. The programs presented were as follows:

January 3—Presidential Address. Philip Batchelder, M.D. "Flocculation Tests in Liver Disease." Robert V. Lewis, M.D., Haffenreffer Fellow in Medicine, Brown University and Rhode Island Hospital. "Medical Public Relations—The AMA and The Rhode Island Medical Society." Charles L. Farrell, M.D., Chairman, Committee on Public Policy and Relations of the Rhode Island Medical Society.

February 2—"Some Aspects of Aviation Medicine." Captain Julius C. Early, Jr., MC, USN, Staff Member, Division of Aviation Medicine, Bureau of Medicine and Surgery, Navy Department of Washington, D. C. "Medical Aspects of Atomic Warfare." Captain Charles F. Behrens, MC, USN, Medical Officer in Command, Naval Research Institute, Bethesda, Maryland.

March 7—"Red Cross Activities." Lucius C. Kingman, M.D., Member Executive Committee, Providence Chapter, A. R. C. "First Aid Program." Mr. Carl V. Slader, Director of Safety Services, Providence Chapter, A. R. C. "First Aid By Police." Superintendent E. Ralph Bonat, R. I. State Police. "The Rescue Squad." Mr. Charles E. Quinn, Chairman Committee on Disaster and Rescue, Governor's Fire Prevention Conference. Demonstration: Lt. Charles Potter, Providence Fire Department. "National Blood Program of the American Red Cross." Mr. Charles G. McEachram, Program Director, North Atlantic Area, A. R. C.

April 4—"Kaposi's Variscelliform Eruption." Stanley S. Freedman, M.D., Associate Physician, Department of Pediatrics, R. I. Hospital, and John T. Barrett, M.D., Senior Resident, Department of Pediatrics, R. I. Hospital. "Recent Trends in Surgery of the Thorax." J. Murray Beardsley, M.D., Visiting Surgeon, R. I. Hospital.

May 2—"The Providence Veterans Administration Hospital." William Sullivan, M.D., Superintendent. "Health Insurance—Voluntary or Compulsory?" Charles J. Ashworth, M.D., Member, Committee on Public Policy and Relations, R. I. Medical Society.

October 3—"The Diabetes Detection Program." Louis I. Kramer, M.D., Chairman, Committee on Diabetes, R. I. Medical Society. "Treatment of Malignant Lymphomas with Nitrogen Mustard." Herman A. Lawson, M.D., Chief, Medical Services, U. S. Veterans Hospital. William J. H. Fischer, M.D., Assistant Physician, Outpatient Department, R. I. Hospital. "Prepaid Surgical Insurance for Rhode Island." Charles J. Ashworth, M.D., President-Elect, R. I. Medical Society; Member, Health Insurance Committee.

November 7—"Carcinoma of the Tongue." Thomas Perry, M.D., Assistant Surgeon, Out-patient Department, R. I. Hospital. "Spontaneous Rupture of the Abdominal Aorta with Report of a Case." Seebert J. Goldowsky, M.D., Assistant Surgeon, R. I. Hospital.

December 14—"The Basis for Oxygen Therapy." Meyer Saklad, M.D., Chief Anaesthetist, Department of Anaesthesia, Rhode Island Hospital. "The Emotional Factor in the Practice of Medicine." Wingate M. Johnson, M.D., of Winston-Salem, North Carolina. "Sickness Insurance in Scandinavia and England." Creighton Barker, M.D., of New Haven, Connecticut.

The Executive Committee held four meetings during the year to act upon matters relating to the operation of the Association. Included in its work was the review, with subsequent approval, of the applications of ten physicians for active membership, two for associate membership, three for transfer to other medical societies outside Rhode Island, and the exemption of seven members from dues by reason of their age or illness.

During the year the following members of the Association died:

Michael J. Nestor, M.D., (January 9)
Edwin G. Thompson, M.D., (May 11)
John A. Gormly, M.D., (August 18)
Stephen A. Welch, M.D., (September 7)
Edward L. Myers, M.D., (November 10)
John A. Young, M.D., (December 6)
James F. McGinn, M.D., (December 31)

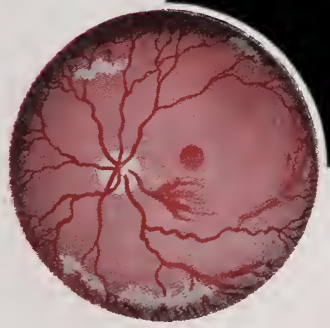
This is merely a summary report by your Secretary. A careful reading of the reports of the various committees

continued on page 98

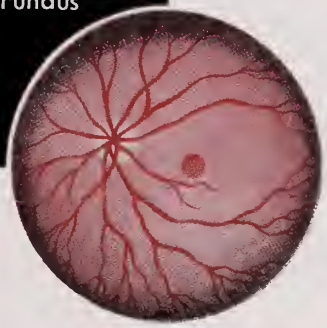
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Ocular Fundus in Degenerative Vascular Disease—Hypertension, Diabetes, Arteriosclerosis —note tortuous blood vessels, areas of exudation, hemorrhagic areas.



Normal Ocular Fundus



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*RUTAMINAL is the trademark of Schenley Laboratories, Inc. and designates exclusively its brand of tablets containing rutin, aminophylline, and phenobarbital.

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A general purpose milk produced under strictest sanitary requirements, and subjected to the process of homogenization so that your patients may enjoy the advantages provided by milk of this type.

Features Your Patients Will Appreciate

- Every glassful has its full quota of wholesome nourishment.
- Tastes richer — same amount of cream in every drop.
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- Ideal for all — as it offers wholesome nourishment and uniform proportion of cream.

A. B. Munroe Dairy

102 Summit Street East Providence, R. I.

Tel.: East Providence 2091

ANNUAL REPORTS—1949

continued from page 96

which will be published in the RHODE ISLAND MEDICAL JOURNAL within the next month will give further insight into the many activities carried forward for the membership during the year.

Respectfully submitted,
DANIEL V. TROPPOLI, M.D., *Secretary*

ANNUAL REPORT OF THE TREASURER — 1949

RECEIPTS:		
Cash balance on hand, January 1, 1949	$1,103.71	
1949 dues and miscellaneous receipts	7,395.00	
		$8,498.71
EXPENSES:		
Committees	$ 249.20	
Collations	275.00	
General Expenses	833.81	
Journals	625.54	
Library (night attendant)	291.00	
Medical Bureau	1,400.03	
Office Supplies	31.27	
Postage and Printing	529.50	
R. I. Medical Society	1,552.89	
Salaries	1,791.40	
Taxes	356.72	
Telephone	229.06	
		$8,165.42
Cash on hand, January 1, 1950		$ 333.29
Invested U. S. Treasury Bonds		2,740.00
Total assets, January 1, 1950		$3,073.29

J. M. BEARDSLEY, M.D., *Treasurer*

ADVISORY COMMITTEE TO THE COMMUNITY WORKSHOPS

During 1949 there has been no meeting of the full committee. The Executive Committee of the Community Workshops has consulted the chairman of your committee on occasion, and members of your committee have assisted the Community Workshops in a number of matters which did not require concerted action.

CLIFTON B. LEECH, M.D., *Chairman*
RAYMOND F. HACKING, M.D.
WILLIAM A. HORAN, M.D.
LOUIS A. SAGE, M.D.
NATHAN A. BOLOTOW, M.D.
CATHERINE ZOURABOFF, M.D.
JOHN LANGDON, M.D.

COMMITTEE ON LEGISLATION

The Committee on Legislation of the Providence Medical Association has held no formal meeting during the past year. Through arrangement with the Mayor's office, various items pertaining to health which were to appear or had appeared before the City Council were called to our attention. We were aware of none that were of controversial nature and therefore no action was undertaken.

FRANK B. CUTTS, M.D., *Chairman*
ALBERT H. JACKVONY, M.D.
JAMES FAGAN, M.D.
HENRY S. JOYCE, M.D.
UBALDO E. ZAMBARANO, M.D.

AIR POLLUTION ABATEMENT

A program for Air Pollution Abatement in this city was started by the Providence Medical Association in January 1945 under the presidency of Dr. B. Earl Clarke.

During this five year period interest has been stimulated and your committee, representatives of the Providence Chamber of Commerce, and other civic groups assisted the City of Providence in the adoption of a modern ordinance for control of Air Pollution.

This ordinance was legalized just three years ago and during this period the city has made a laudable effort toward enforcement.

Three members of your committee, Drs. Burgess, Corvese, and Cameron have represented the Providence Medical Association in public meetings on Air Pollution control in the past year.

The Providence Journal Company is to be commended for its continued support of the program.

The Providence League of Women Voters has been especially active in support of the effort to clear the air of Providence. A Smoke Abatement Forum opened to the public was held by this organization in this city last October 27.

Mr. William G. Christy, of New Jersey, an expert in the field of Air Pollution Abatement, gave a number of valuable suggestions at this meeting. Mr. Christy believes that the program in Rhode Island should be regional and not local. His written report to the League of Women Voters contains the following paragraph.

"Program should be regional. Air Pollution knows no political or governmental boundary lines. Providence will never have clean air until there are air pollution laws and regulations in your Metropolitan district. If all the sources in your City are cleaned up, smoke, dust and fumes would still blow over Providence from the municipalities around it. The best way to accomplish this in your community is to have State Legislation."

This would seem to be a logical viewpoint in consideration of this state's geographical pattern.

Conclusions:—It is felt that progress has been made in clearing our Providence air but that much continued effort is needed to achieve satisfactory results.

A State Enabling Act for control of Air Pollution throughout the state came out of a sub-committee composed of members of the Chamber of Commerce and Providence Medical Association and was passed by the General Assembly in 1946. We recommend at this time that the present Providence Medical Association committee be terminated and that a new Rhode Island State Medical Society Committee for Air Pollution Abatement be set up.

FRANK M. ADAMS, M.D.
ALEX M. BURGESS, M.D.
EDWARD BURKE, M.D.
ANTHONY CORVESE, M.D.
EDWARD S. CAMERON, M.D., *Chairman*

PRE-SCHOOL EXAMINATIONS

The Committee on Pre-school examinations held a meeting in April 1949 and discussed the ways and means of emphasizing pre-school examinations for children about to enter schools. The success of the summer "Round Up" program depends upon two factors, namely; the activity of the Parent-Teacher's Association and the insistence on the part of the School authorities on having such a record as a requisite for admission to school. In the smaller communities around Providence this program is very successful because the single Physician is also the School Physician and it is a very simple matter to organize community spirit and carry this program through to a success-

continued on next page

(ammonia dermatitis)
DIAPER RASH
Diaparene
TABLETS + OINTMENT
THE ANTI-AMMONIACAL RINSE FOR NIGHT DIAPERS
THE WATER-MISCIBLE ANTI-BACTERIAL FOR DAY CARE
Prescribed together they—
ELIMINATE CAUSE OF DIAPER RASH!
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380 Second Avenue, New York 10, N. Y.
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Please send me, without cost, literature and samples of DIAPARENE Tablets and Ointment to eliminate cause of diaper rash (ammonia dermatitis) and as an adjunct treatment and deodorant for the side effects of incontinence.
Dr.
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City Zone State
MAIL THIS COUPON TODAY

ful completion. However, in the City of Providence, this program is not so successful due to the fact that there are hundreds of Physicians and numerous schools that are involved in this particular program. An added factor is the School Health Program itself. School children in both public and parochial schools in the City of Providence receive routine physical examinations in the first, fourth, seventh and eleventh grades. A generation ago such examinations had the educational value of showing people the necessity for routine regular physical examinations. Today, however, the individuals begin to think of these school examinations in terms of socialized medicine. As a result parents do not feel that they should take their children to their private physician just before school opens for a simple physical check-up, since the child will receive such check-up at no expense to them in the public or parochial schools.

This Committee feels that in order to advance the preschool examination program on a firm and sound basis, it will be necessary to re-evaluate and replan our school health program along different lines than has been done in the past.

The Superintendent of Health of the City of Providence, in accordance with the above line of planning, will set up a pilot program in two or three of the Parochial schools whose health supervision is under the Health Department, whereby the children in the first, fourth, seventh and eleventh grades will be examined by their private physician or pediatrician and will bring the record of such examination to the school to be entered on the health record card of that particular child. This will require the co-operation of the Medical Profession. The members of this Society must realize that the success of this program depends on them and their co-operation in filling out the required health records of the examinations. Should this pilot program fail because of lack of co-operation from the private physician, then the Department of Health will be forced to return to the present system of school examinations or some similar system which would be more extensive. The result of such an extension would be State Medicine.

JOSEPH SMITH, M.D., *Chairman*
CHARLES B. LEWIS, M.D.
ROBERT M. LORD, M.D.
MERLE M. POTTER, M.D.
JOHN T. MONAHAN, M.D.
MORRIS BOTVIN, M.D.

PRIZE CASE REPORT CONTEST

In the report of this committee for last year it was pointed out that in spite of adequate publicity the contest had aroused little interest and that only two case reports had been submitted during 1948. It was suggested that the Association give serious thought to discontinuance of the contest unless a considerable number of reports were forthcoming in 1949. This year only one paper was submitted and the report was unacceptable to the committee for presentation before the Association.

It is recommended, therefore, that no prizes be awarded for 1949, and that the contest, at least in its present form, be discontinued.

CLARENCE E. BIRD, M.D., *Chairman*
FRANK B. CUTTS, M.D.
ALBERT H. JACKVONY, M.D.
LOUIS I. KRAMER, M.D.
ROBERT H. WHITMARSH, M.D.

continued on page 102



Throat Specialists report on 30-day test of Camel smokers:



"Not one single case of throat irritation due to smoking Camels!"

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.



Long Island housewife Edna Wright, one of the hundreds of people from coast to coast who made the 30-day Camel mildness test under the observation of throat specialists.



According to a Nationwide survey:

More Doctors Smoke Camels

than any other cigarette

Yes, doctors smoke for pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors what cigarette they smoked. The brand named most was Camel!

REPORT OF THE MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION, 1949

Certified Milk in Providence during 1949 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Fairoaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

The legal standard for Pasteurized Certified milk in Providence is 500 colonies per cc. and the actual count in all samples examined by your Commission the past year has been 22 colonies per cc The count on raw certified milk the past year has been 4,069 per cc. while the legal limit in Providence is 10,000 colonies per cc. The credit for this splendid record belongs to the producers of this quality milk.

The American Association of Medical Milk Commissions in their Methods and Standards for the Production of Certified Milk, require that each producer shall make or have made, once per month, a titration of Brucella agglutinins in the whey of the milk, whether the milk is raw or pasteurized. This is being done on Certified milk at Fairoaks Farm and the results to date have been excellent.

Certified milk shall have a coliform colony count of not more than 10 per ml. before pasteurization and must be less than 1 per ml. in route samples as delivered to consumers. During the past year practically all of the samples examined in our laboratory have conformed to this regulation.

During the past year considerable interest in milk has been manifested by various groups in the State. Many people ask how it is possible to produce such a fine milk with low bacterial counts and practically free from Coliform organisms. The presence of these organisms in unpasteurized milk usually indicates unclean milking, contaminated utensils or improper handling of milk. Rarely they may come from infected udders. Their presence in pasteurized milk indicates improper pasteurization or contamination of the milk after pasteurization. Properly pasteurized milk should contain no organisms of the coli-areogenes group.

The Commission is indebted to Professor Stuart of Brown University for his continued cooperation in supervising our laboratory work at Brown University.

Harold G. Calder, M.D., *Chairman*
Reuben C. Bates, M.D. *Secretary*
D. Wm. Bell, M.D. John Langdon, M.D.
Thomas J. Dolan, M.D. Frank I. Matteo, M.D.
Walter S. Jones, M.D. Henry E. Utter, M.D.

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1949

	CHERRY HILL H. P. HOOD			FAIROAKS						HAMPSHIRE HILLS			WALKER-GORDON		
	Pasteurized			Raw			Pasteurized			Pasteurized			Vit. D. Pasteurized		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	3.9	12.40	18	4.4	13.35	4,455	4.0	12.91	11	4.1	12.76	171	3.9	12.40	17
February	4.0	12.40	10	4.4	13.22	2,935	3.8	12.67	11	4.0	12.64	57	4.0	12.39	17
March	3.8	12.25	10	4.0	12.87	2,695	3.8	12.56	6	4.1	12.79	50	4.2	12.58	51
April	3.8	12.23	8	4.1	12.86	2,871	3.8	12.54	9	4.1	12.79	79	4.0	12.41	34
May	3.8	12.24	15	4.0	12.72	2,277	3.9	12.67	9	4.0	12.72	27	4.1	12.43	15
June	3.8	12.37	4	4.4	13.11	4,044	3.7	12.42	5	3.9	12.53	7	3.8	12.19	12
July	3.8	12.33	8	4.0	12.74	3,508	3.7	12.56	19	3.9	12.55	21	3.7	12.15	6
August	3.9	12.49	34	4.2	13.06	3,212	4.0	12.85	73	4.1	12.96	14	3.9	12.40	14
September	3.9	12.57	4	4.2	13.01	2,438	3.9	12.59	22	4.1	12.96	5	4.7	13.12	23
October	3.9	12.53	6	4.3	13.35	4,452	4.1	13.05	14	4.2	13.11	4	4.2	12.91	14
November	3.8	12.47	10	4.5	13.00	10,550	4.1	12.69	26	4.2	12.85	5	3.9	12.27	11
December	4.0	12.82	50	4.2	13.05	5,400	4.1	12.92	9	4.1	12.98	17	4.1	12.84	10
Yearly Average	3.9	12.42	14	4.2	13.02	4,069	3.9	12.70	18	4.0	12.80	38	4.0	12.50	19

PUBLIC RELATIONS

The Public Relations Committee of the Providence Medical Association has allied itself and its work very closely with the Public Policy and Relations Committee of the R. I. Medical Society. The members of the committee of the association are all members of the same committee of the state society, and have attended the meetings of the latter committee and assisted in its program to improve our local medical public relations and to foster and promote the present educational program of the American Medical Association. This program is aimed at making the general public more cognizant of the disadvantages and dangers to their health and their freedom inherent in any program of federal-controlled, compulsory health insurance or socialized medicine.

At the meeting of the association held on May 2, 1949, the committee had introduced a resolution which was adopted by the association and which placed it on record as being opposed to "any form of compulsory health insurance or any system of political medicine designed for national bureaucratic control." Copies of this resolution were sent to the A.M.A., and to each senator and representative from the state of R. I.

The committee feels that the time has come when the individual practitioner of medicine himself must pay more attention to public relations. Good medical public relations begin in the office of each and every physician. Further, it has recommended that more of the association's meetings be devoted to presentation and discussion of current trends and problems in medical economics and public relations. In this way only can more interest on the part of each individual practitioner be created. Educational efforts should rightly "begin at home."

Lastly, it is strongly urged that those members who have not already done so, remit at once their contribution of $25.00 to the educational program of the A.M.A. It is a very small price to pay for the future freedom of our profession and of our country itself.

MORRIS BOTVIN, M.D., *Chairman*
CHARLES J. ASHWORTH, M.D.
CLIFTON B. LEECH, M.D.

READING ROOM

The Association paid for subscriptions for 35 journals during 1949. A new periodical, the ARCHIVES OF INDUSTRIAL HYGIENE AND OCCUPATIONAL MEDICINE published by the American Medical Association, has been ordered for 1950. This journal takes the place of OCCUPATIONAL MEDICINE which has ceased publication.

The Reading Room was open 98 evenings during 1949 with a total of 315 visitors. Of these, 111 were physicians. The evening hours are busiest during the midwinter school holidays and in May when many students use the facilities of the Library in gathering material for term papers.

One hundred and fifty-three volumes of journals were bound during the year; seven volumes are at the bindery at the present time.

FRANCIS V. GARSIDE, M.D., *Chairman*
HUGH E. KIENE, M.D.
EDMUND A. SAYER, M.D.

TELEPHONE BUREAU

On September 1 the new 24-hour telephone secretarial service was inaugurated for approximately 160 members of the Association. This Medical Bureau culminated long studies by committees of the Association through the

continued on next page

EVERY MAN AND WOMAN SHOULD DRINK MORE

Certified Milk

BECAUSE

The National Research Council recommends an increase in the minimum daily calcium intake for adults from eight-tenths of a gram to one gram.

Ninety percent of your Calcium Intake is from Milk.

GET THE BEST — GET CERTIFIED MILK

Ask for it by name from your MILKMAN, in your GROCERY STORE and at your FAVORITE EATING PLACE

years, and in the four months of its operation it has fully justified all the predictions made for its success.

Under the supervision of Mrs. Mary H. Beagan, and a staff of seven operators, the Bureau has made rapid progress from the difficult starting stage until now it has won wide approval by the membership. The number of subscribers with a private loop now totals 175, and new members are joining weekly. In the immediate future the Bureau will make available to members of the Association an alternate listing service to be effective with the release of the 1950 telephone directory.

In addition to its service for the profession the Bureau has expanded its activities to handle emergency calls for the services of physicians. More than 350 such calls had been serviced in the first four months of operation, with physicians from a class list compiled by the Association answering the emergencies. The tremendous value of this community service cannot be rated too highly. It is a program that warrants the active support of all members who should register to accept their share of emergency calls from the greater Providence area.

The initial expense for establishing suitable facilities for the Bureau in the basement room of the Medical Library has been borne by the Association and the Rhode Island Medical Society, and as the Bureau progresses this debt will have to be cleared. The Bureau is presently spending practically all its income in its effort to provide the most efficient round-the-clock service to its subscribers.

JOHN G. WALSH, M.D., *Chairman*
HENRY S. JOYCE, M.D.
E. VICTOR CONRAD, M.D.
NATHAN S. RAKATANSKY, M.D.
WILLIAM P. D'UGO, M.D.

TUBERCULOSIS

This year, your Committee has been interested primarily in following up its interest in tuberculosis control in various groups of people. Last year, our interest was aroused in the matter of tuberculosis control in the schools of Rhode Island, and this year, after discussing the matter with Public Health officials and educational leaders in the State and reviewing the programs followed out elsewhere, we have developed a program for this State, which has been presented to the Rhode Island Department of Education. Dr. Michael Walsh, the Director of this Department, has been most cooperative and has expressed a real interest in the program. He has encouraged its use in the schools throughout the State, and the Tuberculosis Committee has offered its services in any way that it can be helpful in carrying out the procedures involved.

IN OLNEYVILLE IT'S . . .
McCAFFREY INC.
Druggists
19 OLNEYVILLE SQUARE
PROVIDENCE 9, R. I.

As usual, the activities of this Committee have been carried on in conjunction with the Committee on Tuberculosis of the Rhode Island Medical Society.

The following is a copy of the report and recommendations for control of tuberculosis in our schools:

There are several reports of cases of active tuberculosis in adults intimately associated with institutions where considerable numbers of people of school age congregate. These reports have shown a high tuberculosis morbidity and mortality among the young people with whom these adults came in contact.

Thus, it is seen that the grouping of large numbers of young people in schools give a large potentially fertile field for the spread of tuberculosis. One tuberculous individual in this environment is more likely to spread tuberculosis than is a similar individual in most other enterprises.

There are obvious reasons for this: 1) Contact is frequently intimate. 2) Contact is frequently prolonged. 3) This intimate prolonged contact is usually with a considerable number of people and 4) these people are young and consequently highly susceptible to tuberculous infection and disease.

If for no other reason than the above, it is desirable that a careful and systematic routine of chest x-raying be carried out on all adults that come in intimate contact with institutional groups of people of school age. Besides this reason, however, there are others. Firstly, it gives a high degree of protection to the individual who is x-rayed by way of revealing lesions of tuberculosis and other chest conditions in an early and treatable stage; secondly, there is considerable educational value from a public health point of view.

Therefore, we emphatically recommend the following program to be carried out systematically in our colleges — State, classical, and business; our schools — public, parochial, and private, and in any other institutions, associations, or groups where people of school age congregate, especially within doors:

1. All persons who in their employment come into close contact with organized groups of people of school age should have a medical examination that includes an x-ray of the chest at the time of first employment.

2. An x-ray of the chest should be repeated at annual intervals during their employment and at such other time as there may be symptoms reasonably suggestive of a persistent disease of the lungs, e. g., a) cough lasting two weeks, b) severe sharp chest pain without other obvious cause, c) spitting of blood, d) unexplained loss of weight.

3. Any person showing suggestive evidence of active tuberculosis should sever this intimate contact until whatever diagnostic studies that may be indicated have been carried out to prove or disprove the presence of such condition.

4. If these studies indicate the presence of active tuberculosis, the severance of contact should be maintained.

5. Contact should be resumed only after the disease has become "arrested." The Director of Tuberculosis Control having jurisdiction in the area involved should have the authority to require corroborative opinion through his own office or that of a recognized chest physician before contact is resumed.

6. After resumption of contact, the previously recommended examinations should be carried out at a minimum of three months' intervals for the first year and at six months' intervals for the next two years, and, if indicated, may remain under the supervision of the Director of Tuberculosis Control for a longer period.

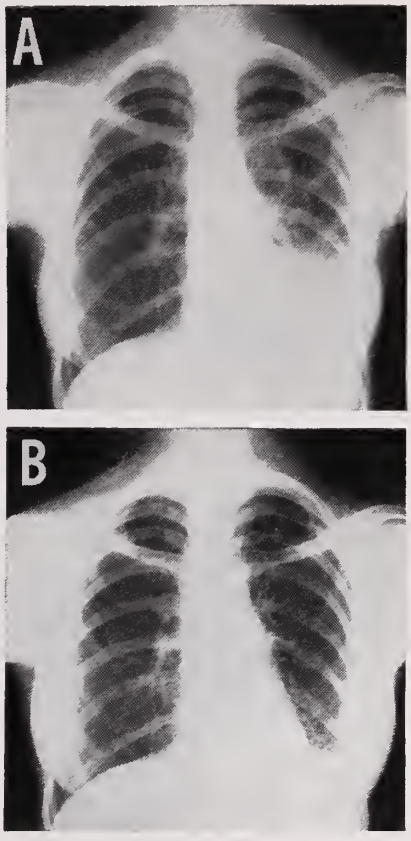
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Effective Chemotherapy in TUBERCULOSIS

Streptomycin or Dihydrostreptomycin, used alone or in combination with para-aminosalicylic acid, is recognized as a valuable and, in some instances, an essential adjuvant in the treatment of selected types and stages of tuberculosis.

Para-aminosalicylic acid is capable of inhibiting or significantly delaying the emergence of bacterial resistance to streptomycin or dihydrostreptomycin.

These drugs are not to be regarded as substitutes for traditional therapeutic methods. Rather, they serve best when properly integrated with bed rest and, where necessary, collapse measures or other forms of surgery.



A. Before Treatment *(9 days prior to Dihydrostreptomycin therapy) Diffuse lobular tuberculous pneumonia, lower half of left lung; thin-walled cavity above hilus (3 x 3.5 cm.).*

B. After 3 Mos. Treatment *(2 days after discontinuance of Dihydrostreptomycin) Considerable clearing of acute exudative process in the diseased lung; cavity smaller and wall thinner.*

Detailed literature on the subject of chemotherapy in tuberculosis will be supplied upon request.

MERCK & CO., Inc.
Manufacturing Chemists
RAHWAY, N. J.

Merck Antitubercular Agents

Streptomycin Calcium Chloride Complex Merck

Para-Aminosalicylic Acid Merck (PAS)

Dihydrostreptomycin Sulfate Merck

BOOK REVIEWS

AESCULAPIUS COMES TO THE COLONIES by Maurice Bear Gordon, M.D. Cloth. Price, $10. Pp. 560 Ventnor Publishers, Inc., Ventnor, N. J.

In this splendidly printed and generously illustrated book, Dr. Maurice B. Gordon presents the first comprehensive survey of the history of medicine in the thirteen original colonies. The book was written during the busiest period of the author's professional life; he tells us that until its completion, whether his day's work ended at 10:00 P.M., midnight or 2:00 A.M., he made it his habit to devote at least two hours in each twenty-four to the pursuit of this study. The result is a comprehensive story of the founding fathers of American medicine.

Dr. Gordon writes no mere dry narrative of the lives and professional activities of colonial doctors; he spreads a wider canvas and describes, for each colony, the social and political environment in which our medical forebears lived and worked. In colonial times many doctors were greatly interested in politics, an interest which accounts for the fact that five physicians signed the Declaration of Independence. Of these political interests the author writes entertainingly, employing for his purpose numerous quotations from original accounts, the reproduction of colonial documents, the use of illustrations pertaining to colonial medicine, and abstracts from contemporary newspaper articles and advertisements. Many of these sources are reproduced as illustrations, so that the book contains perhaps the most complete collection to date of illustrations pertaining to colonial medicine.

Those of us who practice in Rhode Island will naturally wish to know what the author has to say about colonial medicine in this state. The chapter on Rhode Island runs to thirty-two pages and gives an account accurate, if brief, of men and events in colonial days. It was the great seaports in colonial America that became the leading medical centers. It should not be forgotten that after the ports of New York, Philadelphia, Charleston and Boston came Newport which was not far behind as a port of entry. It was the second port of New England, Boston alone outranking it. In Newport resided Dr. John Clarke, physician and theologian who was banished from Boston with Roger Williams. To Newport came also Bishop Berkeley and his famous tar water which he proclaimed would "cure or relieve most, if not all diseases." With his friends the Bishop founded the company of the Redwood Library, of which Ezra Styles, Congregational minister, later the president of Yale College and "the most learned man in America", was for many years the librarian. It was Ezra Styles who played a leading part in the establishment of Rhode Island College (Brown University) in 1764. An interesting entry in the diary of the Redwood family reads as follows: When the establishment of a college at Rhode Island was first contemplated, by certain persons of the Baptist Society (a people who have panted after learning in order to be able to give a reason for the faith that is in them) Mr. Redwood was applied for aid, when he offered to give a thousand pounds sterling, on condition that it would be erected on Rhode Island. But an association of wealthy individuals in the town of Providence, chiefly of the family of the Browns offered still more, which happily fixed its location there.

William Hunter age twenty-two, who had studied medicine at Leyden arrived in America in 1752. He settled in Newport where he became a prominent practitioner, the first male accoucheur in the colony and the first in America to give a systematic, advertised course of public lectures on anatomy and surgery. The lectures were given in the Old Colony (State) House. Newport was the birthplace of the gifted Benjamin Waterhouse, the first professor of theory and practice of medicine in Harvard Medical College and one of the earliest advocates of vaccination in the colonies.

By 1800 the Providence population had increased to 7614 from 3452 in 1748. The leading medical luminaries were the Bowens and Drs. Browne, Throop and Wheaton. When Rhode Island College was moved from Warren to Providence in 1770 it became Brown University and was empowered to confer degrees in theology, law and medicine. Its first exercise of this power was the conferring of the degree of M.D. on Solomon Drowne.

From many interesting items concerning medicine and physicians in colonial Rhode Island we have selected the above merely to illustrate how well Dr. Gordon has covered the story of colonial medicine in our state. The chapters on the other colonies are equally entertaining and informative.

continued on page 109

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BOOK REVIEWS
continued from page 106

There is an excellent bibliography and a helpful index.

When Aesculapius came to the colonies he brought with him, to be sure, not much in the way of scientific medicine, but a goodly supply of manliness, resourcefulness and courage, tinctured now and then, with not a little jealousy and vindictiveness. However, in a rugged country, against great odds, he did a commendable job, the story of which we, in a leisure hour, may read to our advantage in Dr. Gordon's excellent book.

John E. Donley, M.D.

DISEASES OF THE HEART by Charles K. Friedberg, M.D. W. B. Saunders Company, Phil., 1949. $11.50.

This book is no pocket edition or "primer". It consists of 1081 good sized pages which are divided into six sections and forty-nine chapters. The various sections are headed as follows: 1) Circulatory Failure. 2) Cardiac Arrhythmias. 3) The Coronary Circulation and Disturbances In Cardiac Blood Supply. 4) Structural Abnormalities of the Heart. 5) Etiologic Forms of Heart Disease. 6) Special Problems In Heart Disease, the last including a discussion of pregnancy and heart disease; the cardiac patient as a surgical risk; and insurance and medicolegal problems in cardiac disease. The discussion is full and, at times, rather complicated. For example, on page 54 in discussing cardiac failure this sentence appears: "Recent studies indicating that muscular contraction occurs through physical changes in the actomyosin system, that potassium is released from actomyosin in the presence of acetylcholine and that the splitting of adenosinetriphosphate supplies the energy for recharging may also yield information as to cardiac contraction and myocardial disturbance in heart failure." To the reviewer such sentences were fully as confusing as they were clarifying.

The book is completely up to date and the author has obviously gone to great pains to include all recent developments. For example, there is an adequate discussion of Thiomerin as a diuretic, the newest concept for the origin of auricular flutter is well included, and the use of Dicumarol is briefly detailed. A few minor errors were noted such as the fact that in Fig. 23A an example of 2-1 heart block is labeled merely as a prolonged P-R interval, and Fig. 23B is upside down in the illustration. In general, however, the diagnostic and therapeutic recommendations are sound and according to well recognized concepts. The book is sturdily bound, the paper and printing are excellent, and the illustrations are clearly reproduced. The illustrations, incidently, consist almost entirely of electrocardiograms and reproductions of x-ray photographs. It is possible that words could be reduced and clarity improved if more illustrations and diagrams were included illustrating structural and pathological abnormalities. The reviewer was particularly impressed by the excellent bibliography which follows each chapter. This adds very considerably to the value of the book. The volume is well indexed.

In the preface the author states "This book endeavors to provide a comprehensive and integrated exposition of the diseases of the heart." In general he fulfills his purpose. The book is of value and can be recommended to the more advanced student or one particularly interested in cardio-vascular disease. A beginner or a general practitioner with only casual interest in heart disease will find the going heavy.

Frank B. Cutts, M.D.

MEDICINE THROUGHOUT ANTIQUITY by Benjamin Lee Gordon, M.D. Published by F. A. Davis Company.

This is a handsomely gotten up book of some 800 pages, well-printed on glossy paper which lends itself to the many interesting illustrations. I doubt if it is read by large numbers of people. It is exceedingly erudite. Dr. Gordon must be a great scholar and, of course, a tremendous worker.

He starts with prehistoric medicine. That means that the early part of his book is founded largely on surmising from what we can learn from old bones found in caves, and we are really getting quite modern when we get around to Egyptian hieroglyphics. The books carries us through the time of Galen, who was born in A. D. 131. We should consider that the study of what the author calls the paleolithic evidence of the antiquity of medicine was rather anthropology.

When we get down to the period when writing came in then there was some real evidence of crude medicine. He talks of a good number of definite periods as that of ancient Egypt, China, the Hebrews and the Greeks.

It would make an excellent book for curious minded doctors, although we do think that after all this enormous amount of work had been done it should have been made much more accessible by a more complete index. For instance, we saw in one place reference to Hygeia and Panacea, the daughters of Aesculapius, but when we wished to refer to this again apparently there was no way to find it except by a long hunt.

The book is evidently a labor of love and I am sure its author must be satisfied even though it will always be far from a best seller.

Peter Pineo Chase, M.D.
continued on next page

GERIATRIC MEDICINE. THE CARE OF THE AGING AND THE AGED. Edited by Edward J. Stieglitz. Second Edition. W. B. Saunders Company, Philadelphia and London. 1949. $12.00

The term "Geriatrics" was introduced quite recently. But it is well-known that the problems of old age have attracted attention of the physicians for a long time as well as that of the philosophers and naturalists.

During the last centuries there appeared a great amount of the works which have tried to elucidate nature and causes of the senile changes. Many theories of aging have been proposed. Many attempts have been undertaken to make clear the enigma of the macrobiotics, or in ancient words, "the art of prolonging the span of the human life." At the same time there were published also the numerous books devoted to the diseases of "old age." Many of them have not lost clinical interest until now. If only to mention the most important of them, I may list the distinguished works of Geist, 1860; Charcot, 1866; Demange, 1886; Schwalbe, 1909 and Schlesinger, 1914.

"Geriatric Medicine" edited by Edward J. Stieglitz and newly appeared in the Second Edition treats mostly of the same subject. But what a striking progress medical science has made here if we compare this modern contribution to the field of clinical geriatrics with the analogous previous works. This brilliant book is a collection of 44 papers by eminent authorities together with the introduction and a foreword by editor, Edward J. Stieglitz. It gives a detailed and up-to-date account of the diverse disorders of metabolism, mind and nervous, respiratory, circulatory, alimentary, genito-urinary, skeletal and cutaneous systems which could be established in elderly and old patients. It should be mentioned that many of them are common in all the periods of life. However, in old age their symptomatology, course, prognosis and therapy are distinguished by a lot of peculiarities in dependence upon the unavoidable senile transformations.

It is a great value of the given book that these important topics of the clinical geriatrics were analyzed here very thoroughly. Maybe only in the recent book of Bürger (Alterskrankheiten, Leipzig, 1947) we can find such a detailed description of the sensile forms of pneumonia, anemia, heart failure, hypertensive cardiovascular disease, Bright's Disease, Cholecystitis, Diabetes mellitus, Arthritis, lesions of the skin, etc.

There are of great interest too the special chapters devoted to the medical care of old people, the principles of geriatric surgery, anesthesia and physical therapy not to mention the countless practical advices concerning the diagnosis and treatment of the elderly and old patients which can be found in the various sections of this book. But the chief emphasis is placed here on another and maybe more important side of the clinical geriatrics, namely on the diseases of "old age," in the narrow sense of the word—the diverse arteriosclerotic alterations, hypertensive cardiovascular disease, pulmonary emphysema, prostatic hypertrophy, senile mental changes, etc., which occur often in the later decades and increase sharply in incidence with advancing years. They are characterized by insidious onset, silent course for a long while, followed by slow but inevitable progression and consequent failure of the various organs and systems with many chronic almost incurable disorders, rather long periods of disability and finally by premature death.

Many of them, especially arteriosclerosis, occur so often in old persons that they have been usually regarded as some inherent corollaries of the senility, fatal sequelae of the aging processes themselves and therefore maladies beyond any therapeutic possibilities. Therefore, one used to consider old age only as a dreadful evil and the precursor of death—liberator from the morose sufferings of old people. This ill repute of senility is routinely transmitted from generation to generation. Because of this belief the problems of old age in the whole have been too often neglected. Till now there has been unfortunately little time and less patience for the aged. Edward J. Stieglitz stresses quite justly the importance of the environmental influences. Indeed, loss of privilege of labor with the consequent forced idleness, "abdication" from the habitual position in life with the concomitant loss of social respect, shortening of the circle of friends, uprooting and loneliness because of the increasing looseness of family ties and vanishing reverence for age being shown not rarely in the present generations—play a certain part amid the causative factors which can precipitate or accelerate the aging. Much can be done to make the life of elderly or old individuals more comfortable and useful.

One of the greatest values of the Edward J. Stieglitz "Geriatric Medicine" is that it shows very conspicuously how erroneous is the idea that senescence means only decline. The authors of this collective book oppose more or less energetically against "the popular assumptions, superficial evidences and the unthinking tendencies to make sweeping generalizations which perpetuate the widespread misconception of old age." It is a great advantage of the given book that there was established more consequently than ever before the essential difference between the normal physiological senility and pathological senility burdened with many quasi inevitable diseases as well as between the chronologic and physiologic age. We find here in the first section of the book the very instructive articles devoted to the physiologic, anatomic and

mental changes occurring wih normal aging, which can be regarded as a valuable addition to the previous works which dealt with the same subject (especially works of Wartin, 1929; Levi; Pepere and Viale, 1933-4; Bastai and Dogliotti, 1938; Cowdry, 1939 and Aschoff, 1938.

It is very valuable too that this book treats not only the senile persons but is even more concerned with the senescent. Of course, the attention of clinical geriatrics must be focused on the critical decades from 40-60 when there begin the mentioned chronic progressive diseases and when medicine has the most chance for their prevention and control. It only is a way to prevent the old people from the premature senile deterioration, from the pathological senile infirmity.

Indeed, there is still much to be learned. Unfortunately the etiology of many diseases of old age (first of all arteriosclerosis) remains till now unknown. Needless to mention how indispensable appear to be the further efforts of the researchers in this difficult and thankless field for the essential progress of clinical geriatrics. No less important is the scientific appreciation of the fundamentals of the biology of the normal aging. Until very recently there has been drawn too much attention to the general theories of aging. But clinical geriatrics requires more the unbiased observations, more the concrete facts and figures about the component elements and multiple facets of the processes of normal and pathological senescence than the abstract speculations about them.

Indeed, the Stieglitz collective work cannot contain the decisive answers to the multiple, not rarely very intricate and sometimes quite obscure questions of clinical geriatrics. The up-to-date level of our knowledge in this domain doesn't permit that.

Nevertheless, this excellent book reflecting modern advances in this given branch of medicine answers very well to the purpose of guiding and advising the physicians who are to deal much with elderly and old people. It stimulates also the further study of these problems.

The need to learn about aging is now urgent. It is a well established fact that old people continue to increase in absolute figures and in relative proportion to the population. As remarks Edward J. Stieglitz, long life without health is not only an individual tragedy, but a social evil. Clinical geriatrics tries to add health to the years of later maturity. Its ultimate aim is longevity with continued health and vigor into ripe senility.

Although old age is distinguished even in normal individuals by a certain decline in some somatic and mental capacities there occur at the same time many important increments in other capacities. For instance with waning powers of speed in adaptation comes compensatory increase in skills. Failing memory for petty details is often offset by bettered judgment. Broader vision, wisdom, greater tolerance and consciousness of social responsibilities, vast experience of life are among the gains of later maturity. In some respects these gains exceed the losses in the balance sheet of life (Edward J. Stieglitz). Full emotional and intellectual maturity of the human personality comes rather late and at best unfortunately to a very few in the present time. Therefore, there is no exaggeration in the assumption that healthy old people can be a very valuable asset to the commonwealth if the potentialities of them are wisely developed, guided and utilized. Really, society functions most adequately when all ages are represented in its structure. I dare believe that this harmonious balance can help our culture to overcome the evil of the numerous "isms" which have clouded the life of our generations almost from the beginning of the present century. I should like to finish this review with the following excerpts from the Stieglitz book:

"Conservation of the health and vigor of the precious and most difficultly replaceable elderly minds should be an essential part of our efforts for defending our culture . . . The future course of events, economic destruction or great enrichment of human life will depend in a large measure upon the science and art of medicine. Such is the vast responsibility of geriatric medicine."

Summing up may I express the hope that this excellent book should be included in the library of every practising physician, general practitioner or specialist alike who deals with aging or aged patients.

IVAN V. BASYLEWYCZ, M.D.

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concluded from page 104

7. The recommended examinations will be done without charge through the office of the Director of Tuberculosis Control acting in the area, if so desired, but may be done by a private physician subject to review by this Director.

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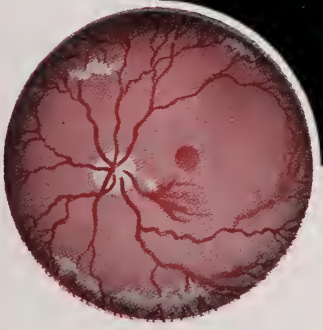


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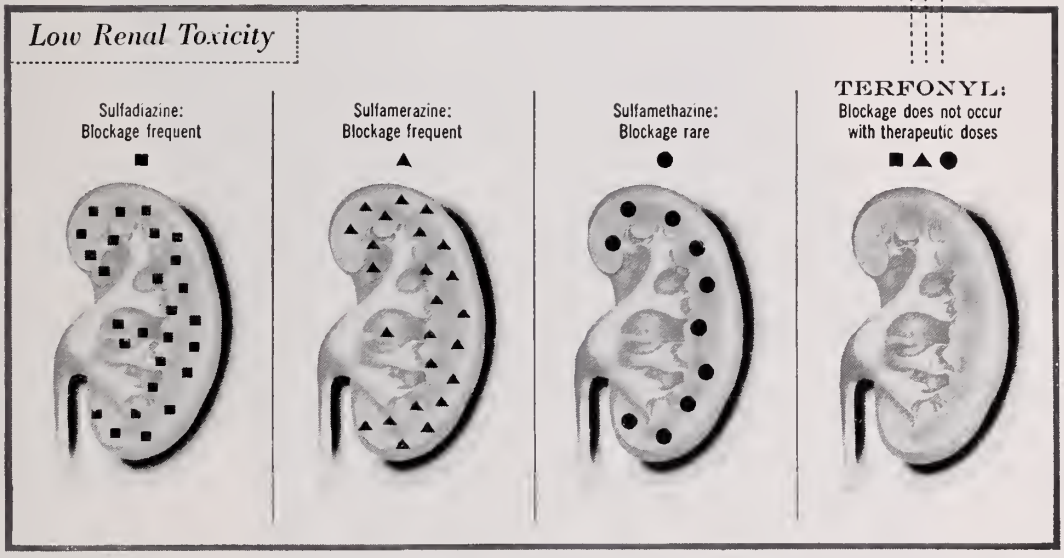
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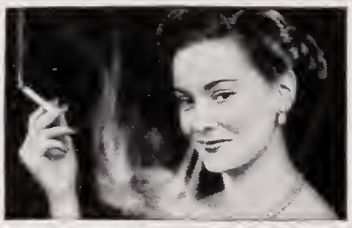
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* *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241-245; *N.Y. State Journ. Med.*, *Vol.* 35, 6-1-25, *No.* 11, 590-592; *Laryngoscope, Feb.* 1935, *Vol. XLV, No.* 2, 149-154; *Laryngoscope, Jan.* 1937, *Vol. XLVII, No.* 1, 58-60

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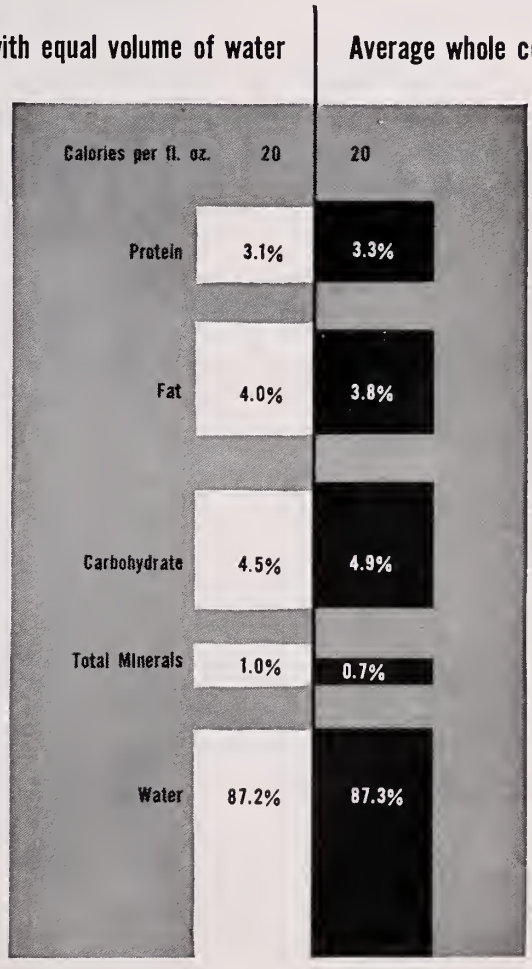
The most recent Reference to this Brewer specialty is:
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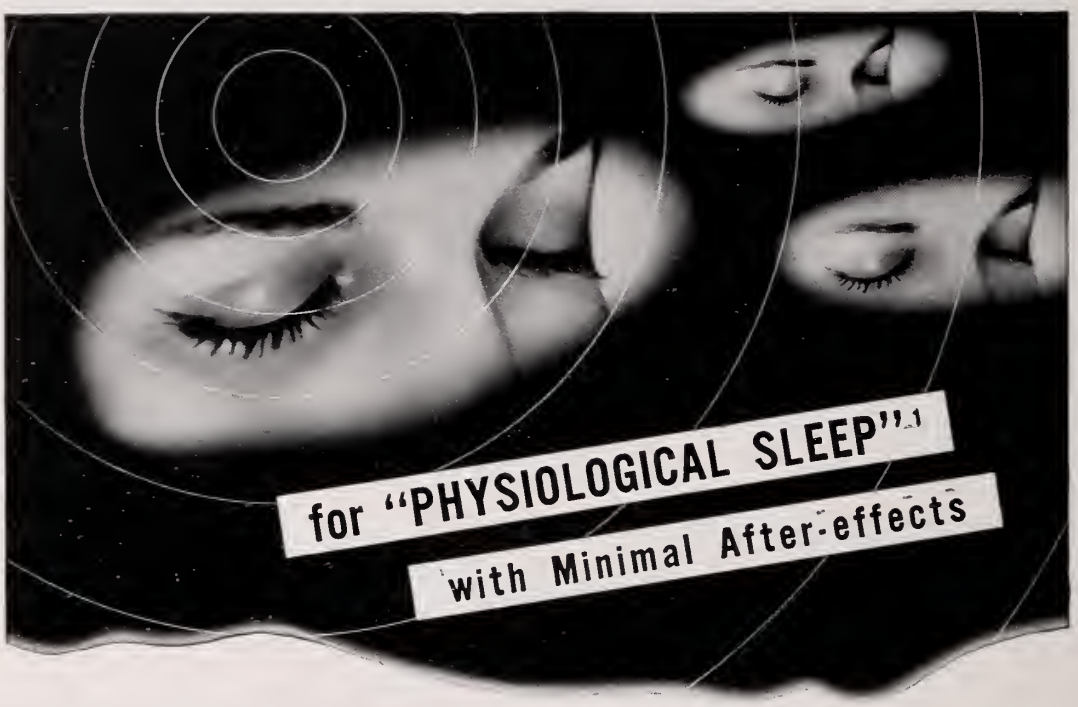
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[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXIII MARCH, 1950 NO. 3

THE IMPORTANCE OF DIET IN THE TREATMENT OF DIARRHEA IN INFANCY*

EDWARD SCOTT O'KEEFE, M.D.

The Author. *Edward Scott O'Keefe, M.D., of Lynn, Massachusetts. Pediatrician, Union Hospital, Lynn; Consultant Pediatrician, J. B. Thomas Hospital, Peabody; Formerly, Pediatrician, Massachusetts General and Carney Hospitals, Boston; Formerly, Instructor in Pediatrics, Harvard Medical School.*

CONTRARY to the general impression a high calory diet can be given to infants suffering from diarrhea without aggrevating the local intestinal condition. While it is admittedly good practice to spare a diseased organ, we should bear in mind that, in diarrhea, the whole intestinal tract is not affected. The affected part is the lining mucous membrane of the intestines and not the tissues concerned with the absorption of the food elements. Consequently, we are under no obligation to spare the portions of the intestinal tract which are not involved in the disease process. On the contrary, we must utilize the absorptive mechanism to its full capacity in order to maintain the patient's general condition at as high a level as possible, so that he may successfully combat the invading organisms. Our problem is to reduce the hypermotility of the intestines. The object in so doing is that the patient may absorb nutriment sufficient for his needs.

In the last few years encouraging reports have appeared regarding the efficacy of the sulpha compounds in controlling some of the intestinal infections. The reports are confusing and often contradictory. However, there can be no doubt that chemotherapy is effective on some occasions and apparently of no value on other occasions. This is not surprising when we realize that diarrhea, in infancy, is not due to any one organism but to a great variety of organisms.

In speaking of epidemic diarrhea of the new born Clifford[1] says: "This syndrome is not a pathological entity, but a miscellaneous group of cases of various etiologies, known and unknown, bound together by a common symptom—diarrhea." The situation in the general field of diarrhea is not dissimilar to that just stated. The etiological factors are numerous.

Owing to the multiple etiological factors in diarrhea, and owing further to the difficulty of identifying these factors, an efficient non-specific form of therapy seems most desirable. The treatment to be outlined is non-specific, simple and effective. I refer to dietary therapy, including the use of apple powder.

Diet has always played a prominent role in the treatment of diarrhea in infancy. Unless the sulfonamides or antibiotics of the future are more effective than is the case today, diet will continue to be of paramount importance in this condition. In the past, the standard procedure has included a reduction of all foods ingested, especially the fats, with an elimination of high residue foods. In most of our medical centres the general principles of treatment do not differ markedly from the above.

This method has never proved entirely satisfactory. The local condition in the intestinal tract was not greatly benefited. The general condition of the patient left a good deal to be desired, since loss of weight or failure to gain weight were inevitable consequences of this low calory diet. It was generally felt, and many today share this point of view, that if the intestinal tract could be spared, or rested sufficiently, the diarrhea would be of short duration.

In pursuance of the two above-mentioned aims, namely: (1) reduction of the food ingested and (2) a low residue diet, I feel we have gone to extremes. I refer to the intravenous therapy so commonly practiced in the diarrhea of infancy. The intravenous treatment supplies adequate fluid intake, the optimum proportion of salts to use in intravenous fluids, is still under discussion. Some effort is made to meet the caloric requirements of the

continued on next page

*Presented at a meeting of the Providence Medical Association at Providence, R. I., February 6, 1950.

infant by the addition of glucose to the salt solutions. Blood, plasma and amino acids add up to a rather lame substitute for the natural selection of foods and minerals normally made by the infant's intestinal tract.

The present day treatment of infantile diarrhea seems to me to be a sort of therapeutic nihilism, since nothing is offered in the way of treatment. It is merely a system of supplying the patient with enough fluids and minerals to keep him alive while he is struggling to cure himself as best he may. In other words, the infant is saved from dehydration and left to recover through the medium of his own natural defenses. However, this is not the whole story. The current method of handling these cases not only gives the patient no direct aid but it actually undermines his only natural defense mechanism, viz: the formation of antibodies, since it deprives him to a great extent of the protein intake from which antibodies are presumably formed.

In this connection let me quote P. R. Cannon:[2] "In as much as experimental evidence indicates that globulin production is dependent upon the intake of amino acids and is impaired by the inadequate intake of dietary proteins, it also follows that antibody production must similarly depend upon protein intake." Further, Wissler[3] et al say: "Evidence has been presented indicating that severe protein deficiency, brought about by a prolonged low protein diet, leads to a marked decrease in the production of antibody."

Now let us consider another method of approach to the problem. Instead of reducing the caloric intake, this method actually increases the intake, with the result that the sick infant receives about 33% more calories per Kilogram than the normal well infant, and from 100% to 500% more than many of the infants receiving the minimal or starvation diets.

A high calory diet, orally administered to infants suffering from diarrhea, rests upon a different philosophy than that of cure through starvation. The infant is losing a large amount of essential food stuffs owing to the rapid passage of material through the intestinal tract. A high calory diet compensates for this loss. The food intake is not reduced, it is increased, in order that an adequate amount of all the food elements, salts and fluid may be absorbed, in spite of the increased peristaltic rate. This is possible because the diminished absorption of food elements, which is characteristic of diarrhea, is due to the rapid passage of the food through the intestinal tract rather than to a diminution of the absorptive capacity of the intestines.

I have used a high calory diet in infants suffering from diarrhea. These infants were from a few days to several weeks in age. Except when persistent vomiting, or severe dehydration was present, oral feeding was found practicable from the outset. Intravenous therapy may occasionally be necessary initially, to correct the above-mentioned conditions, viz: the vomiting or marked dehydration.

The diet used consists of apple powder (appella), boiled whole milk, or evaporated milk and water, in equal parts, one of the prepared barley or wheat cereals, one of the strained meat products, preferably beef, and a multi-vitamine preparation.

There are several features of the above diet which require some amplification. The apple powder is an important component of the regime, since it slows the intestinal rate and converts the watery irritating stools into comparatively normal dejections. Contrary to the usual procedure, the fat content of the diet is not reduced, the sugars, however, are replaced by an equivalent amount of starch. The usual four hour feeding interval is reduced to three hours, in order to increase the caloric intake.

I wish to outline some of the details of management, since they are essential to the success of the treatment. It has been my routine to give one level tablespoonful of apple powder, in three ounces of water, immediately before each milk feeding. This can be given in a nursing bottle, provided the hole in the nipple is sufficiently enlarged. Following this substantial amount of fluid, a feeding of whole boiled milk or one of evaporated milk and water is given. The amount of this milk feeding is governed by the age of the infant and is as large a feeding as would be taken by a normal well infant of corresponding age. One to three teaspoonfuls of strained beef is added to the milk at one feeding and a prepared cereal food at another feeding, vitamines and iron are added in the same manner. I was surprised to find that infants of two or three weeks of age could, with impunity, and would, with eagerness, take this very substantial amount of fluid. No vomiting resulted, no excerbation of the diarrhea occurred. A minor difficulty was noted on two occasions. The entire abdomen was found to be dull on percussion. This proved to be due to an accumulation of the apple powder in the intestinal tract. Omission of the apple powder for two or three days corrected this situation. No ill effects were noted. The apple powder was resumed in somewhat smaller doses without any recurrence of the difficulty.

Such a diet supplies for a four Kilogram infant 150 calories per Kilogram, as well as 5.2 gms. of fat, 4.2 gms. of protein, 5.6 gms. of carbohydrate and 220 cc. of fluid per Kilogram.

I will show some charts which demonstrate the soundness of the postulate that if the intake of food is increased in diarrhea, the absorption of

food will also be increased. These charts show the weight curves of two groups of infants on a minimal or starvation diet and one group upon a high calory diet. The weight gain in infancy is the best single criterion of the progress of an infant, either in sickness or in health, so I have used this as a measure of the relative value of the two forms of treatment under discussion.

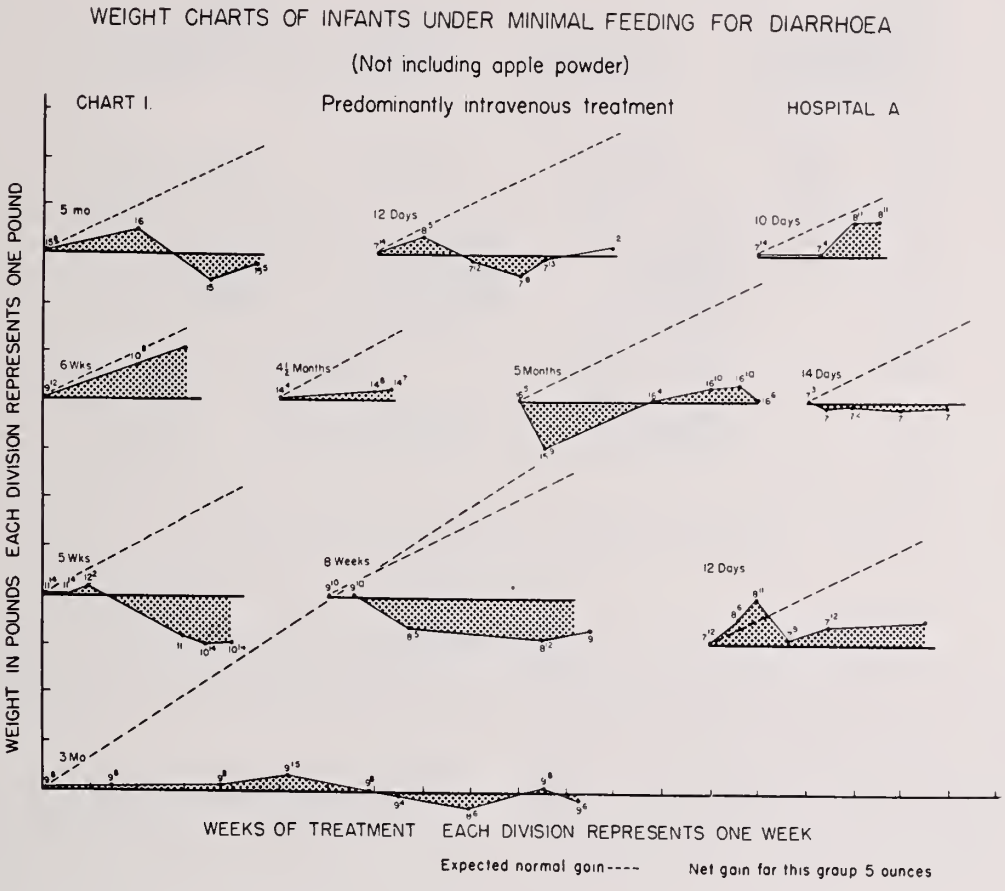


CHART 1

This chart shows the results or the lack of results of the intravenous method of management. The vertical line shows divisions, each of which represents one pound. The horizontal line gives a measure of the time of treatment, each division representing one week. The dotted lines show the expected normal gains. As you will note the expected gains were never realized.

This represents the work of several professors, assistants, residents, internes, social workers, hospital executives, laboratory technicians and a large corps of nurses, ward maids, medical students and by-standers. The work had the approval of a board of hospital trustees, all eminent citizens, selected owing to their ability to raise or to leave money for the benefit of the hospital. Unfortunately none of the latter group knew anything about managing a hospital.

This work was done with a background of marble and brick, starched uniforms and profound airs. Unfortunately for the patients and their parents none of the paticipants in this opus had ever practiced medicine outside of a hospital. Many chemical analyses, bacterial studies and other laboratory procedures too numerous to mention, added to the confusion and to the expense, which was not inconsiderable, in view of the very modest end result of all this effort. When the smoke cleared away this formidable group knew all about every part of the child, but, as the chart shows, they didn't know too much about the child as a whole.

The infants treated in Hospital A spent 350 days in the hospital at approximately $10.00 a day. So you can see that to assemble this armada of workers about this group of sick infants cost $3,500.00, the net gain for the group was 5 ounces. Cost per ounce of gain was $700.00!

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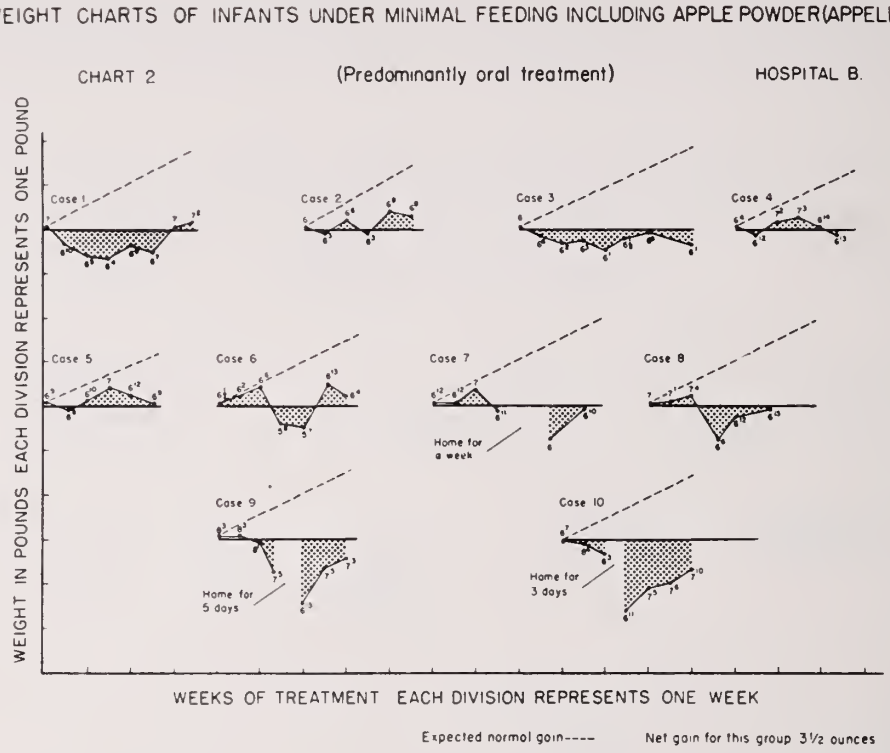


Chart 2

This is also a hospital group. Some intravenous therapy was used but the oral method was predominant. The feeding was minimal. The caloric intake was well below the requirements of a normal infant and far below my idea of the requirements in diarrhea. The results are far from satisfying. The net gain for this series was three and one-half ounces. The cost of care for the whole group was approximately $2,415.00, making the cost per ounce of gain $690.00.

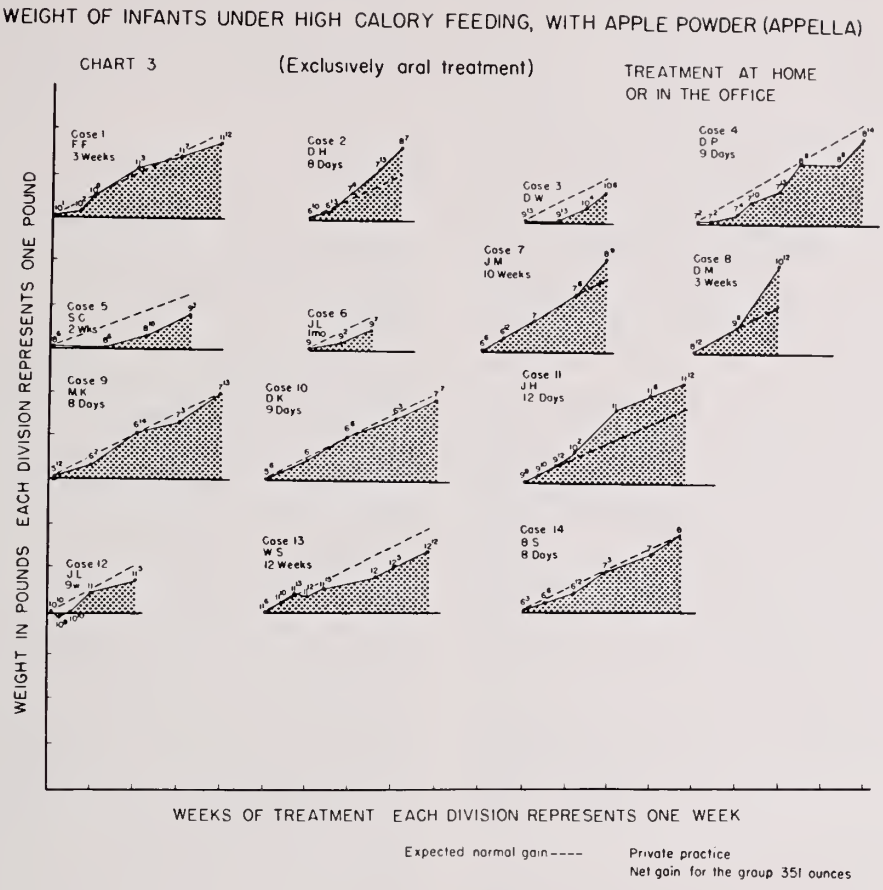
Chart 3

The third chart represents what was done in private practice by one physician without assistants, hospitilization or complicated laboratory procedures. The feeding was exclusively oral. Apple powder was used in conjunction with a high calory diet. The expected gain was usually approximated and at times was exceeded. You will recall that the net group gain in the first hospital series was 5 ounces, in the second hospital group the net gain was 3½ ounces. The net gain in the private practice group reached the amazing figure of 351 ounces, seventy times as many ounces as were produced in one of the hospital groups and one hundred times as many ounces as were recorded for the second hospital group! The cost of care for this group was $660.00, which includes the physician's fees and an allowance of $10.00 a week for food and medicines. The cost per ounce of gain was $1.90. When this figure is compared with the hospital costs of $700.00 and $690.00 per ounce, the question arises as to how long the hospitals can stand competition of this sort.

The almost unbelievable discrepancy between the results and the cost of the hospital series and the results and cost of the series in private practice may well raise the question of whether or not the comparison is fair. I believe it is. Each of the hospital series is composed of cases which arose within the hospital walls during an epidemic of diarrhea. Each series was unselected. This is mentioned to remove any impression that the hospital series were composed of difficult cases received from private physicians. This is not the fact. Each series represents all shades of severity; each series is composed of unselected cases. Likewise, the cases from private practice were unselected, "run of the mine" cases.

Support of the above observations appears in recent work of Chung and Holt[4]. They found in a study of infant diarrhea that a liberal diet, as compared to a minimal or starvation diet, resulted in an increased absorption of the total ash, water, sodium, potassium, calcium, chloride, fat and nitrogen.

The high calory oral feeding of infants with diarrhea is much superior to the starvation or minimal feeding so commonly practiced, in that the natural defenses, viz: the antibodies are given an opportunity for full development and full



functioning. The extra calories supplied compensate for the food lost owing to the accelerated intestinal rate which occurs in diarrhea. Its simplicity of administration further recommends it in contrast to the laborious, expensive and highly artificial intravenous method. It is also superior to the minimal oral feeding, which reproduces to a lesser degree the faults of intravenous management. The long standing practice of reducing the diet in diarrhea is based upon the premise that the entire intestinal tract is affected by the disease. I feel that this is a false premise since the absorptive function is clearly unimpaired as demonstrated by the normal weight gains shown in the group given a high calory diet.

References

[1] Clifford, S. H. N. E. Jr. Med. 237:969; Dec. 1947.
[2] Cannon, P. R., Jr., Immun. 44:113; June 1942.
[3] Wissler, P. R., Woolridge, R. L. Steffe, C. H., Jr. Cannon, P. R. Jr., Immun. 52:267; Mar. 1946.
[4] Chung, A. W. and Holt, L. Emmet, Jr. Rev. of Ped., Pol. 2, No. 3, p. 503; Aug. 1947.

GERBER ORATION

WEDNESDAY . . . APRIL 19 . . . At the Medical Library . . . 8:15 p.m.

"RECENT ADVANCES IN SURGERY OF THE ESOPHAGUS"

John H. Garlock, M.D.

Clinical Professor of Surgery, Columbia University

LEGAL HAZARDS OF THE PRACTICE OF MEDICINE*

S. Everett Wilkins, Jr., Esq.

The Author. *S. Everett Wilkins, Jr., Esq., of Providence, R. I. Member, Firm of Hinckley, Allen, Tillinghast & Wheeler; Counsel, Aetna Casualty and Surety Company.*

My talk this evening is designed to be of practical use to doctors who are engaged in active practice. It is not intended to be a learned treatise on the intricacies of the law of negligence with special reference to the law of malpractice. It is, however, an attempt to examine realistically the legal hazards to which the profession is necessarily exposed and to offer suggestions which, if followed, will reduce such hazards.

Admission to practice, conferring, as it does, a high personal privilege, necessarily carries with it certain well defined and serious obligations to the individuals whom you undertake to serve. I think it will be advantageous at the outset to review them and state them.

First: You represent to every patient whom you treat that you possess that degree of learning and skill ordinarily possessed by physicians (or surgeons, as the case may be,) of good standing who are practicing in this state.

Second: You undertake to exercise reasonable care and diligence and to use your best judgment in treating the patient.

I am sure you will understand me when I say that any suggestions that I may advance will assist only doctors who discharge the above obligations. If you have not become qualified and careful through your training and your practice, I am sure I can not improve your lot by talking to you. I am concerned with competent and conscientious doctors who get into legal difficulties by failing to safeguard themselves. In order to take the necessary precautions, however, a complete understanding of these obligations is necessary and in this connection the following statements are pertinent:

1. No duty is imposed on a physician to accept employment, and a doctor's refusal may be completely arbitrary. In other words, you are licensed to practice, and not compelled to.

2. As to charity cases, you do not have to accept them, of course, but when you do accept and treat them, you owe them the duties which I have mentioned.

3. These duties may be increased by contract, but failure to perform the extra duties will be only a breach of contract and will not be a tort. The only substantial difference would be that in an action of contract damages for death can not be recovered, nor can punitive damages. The Statute of Limitations is six years in a contract action and only two years in tort.

Now how do we apply the standards defined by the above duties? The law takes as its standard the "average physician." A doctor after an unsuccessful treatment may say with all honesty: "I did my best." This is, of course, not the standard. This is a subjective test and that of the law is objective. This works, however, both ways, because in the case of a doctor possessing skill and diligence above the average, the subjective standard would be higher than the legal one.

The short answer to the question propounded is that in the average suit for malpractice a jury decides upon the testimony of qualified physicians what the standard is and whether or not the doctor has met it. There is the one great hazard from which many little hazards stem. In the final analysis you will be judged by laymen.

This necessitates the marshaling of facts in easily understandable fashion and it also indicates careful attention to practical considerations which weigh more heavily with laymen than with the profession. I shall discuss briefly those which I consider most important from a jury's point of view.

1. A vital matter in any malpractice suit is the existence of a full and persuasive set of records, records which convey the impression that the treatment given has been scrupulously careful. Ideal records should be kept in every case. They should record the complaint, the symptoms, the diagnosis; they should record clearly what was done, what advice was given; they should show that nothing was neglected and that the law's standards were complied with.

If any patient refuses or neglects to follow advice, this should be noted. In a case of a disobedient or uncooperative patient, it is well to write him a letter pointing out the possible consequences of his

*Presented at a meeting of the Providence Medical Association, at Providence, R. I., February 6, 1950.

unwise course and keep a carbon copy in his file. If good records are kept, the facts contained in them will very seldom be assailed successfully, and in a majority of cases a good record is the best defense. Conversely, a poor record may be a damning indictment.

2. Because in the final analysis you may be judged by laymen, the matter of tact in handling patients is important as well as professional ability. A professional manner and attitude has a considerable effect. It forestalls criticism and engenders confidence. And if you see signs of a failing confidence when things are not going well, in the patient or his family, a very great protection against a malpractice suit is the consultation. If this is timely done, and if your treatment has been adequate, you will be practically impregnable against an unjust claim which ignorance and disappointment may subsequently produce. All of the implications are turned in your favor. It is implicit in demanding a consultation that you were being diligent; it negatives that kind of professional conceit, the self-sufficiency of which is not popular with a jury; and you are securing in a friendly colleague excellent corroborative testimony.

3. I next suggest that it is wise to refrain from over-optimistic prognosis. Disappointment which ensues adversely affects the patient's state of mind and it is in the mind of the patient that the malpractice suit is born. This type of prognosis can be harmful before a jury because, if proved, it becomes clear that the doctor was wrong as to one thing and it then becomes easier for a jury to find him wrong in others.

4. I also think that a word of warning is in order on the subject of what I call "loose conversation." Impulsive "off the cuff" remarks are all too often taken as admissions of guilt and these can be devastating. I shall never forget a case that I tried many years ago (the doctor involved has since deceased) in which one of the worst things with which I had to contend was one of those admissions. In that case a fractured ulna was diagnosed and the patient was sent to an X-ray man where pictures were taken showing arm and elbow. The X-ray report to the physician showed a fractured ulna, nothing more. Weeks later it was discovered that there was also a dislocated radius at the elbow and the doctor was reported to have exclaimed: "Well, that's my fault. I should have found that."

Not a single physician could be found by the plaintiff who would testify against the doctor. Upon receipt of the X-ray report he had acted precisely as he should. The fault, if any, was in the X-ray report. But on the testimony of that admission the case was submitted to the jury, who fortunately exonerated the doctor. They were nine to three, however, for several hours, and I know perfectly well that if the doctor had not been so careless in his talk, he never would have had to endure the ordeal.

5. There is another kind of personal conduct indulged in by doctors which is probably responsible for about seventy-five per cent of all the malpractice cases that are instituted, namely, criticism of other doctors. If a patient is dissatisfied with his progress, changes doctors, that is, of course, something he has a perfect right to do. But when the new doctor upon examining him, remarks, "What horse doctor have you been going to?" or even turns a more subtle phrase, you have a perfect setting for a suit. The patient's state of mind is thereby perfectly conditioned for litigation. He immediately considers himself aggrieved and he thinks, of course, that in his new doctor he has the means of proving his grievance. That his new doctor will, when pressed, emphatically deny the statement (which is usually what happens) never occurs to him. It never occurs to him, either, that his new doctor seeing the case for the first time is probably in no position to pass judgment on previous treatment, at least without consulting the former doctor. But the damage is done and I am personally convinced that most cases are prompted by that loose form of criticism.

The matters discussed above are the kind that count when you are before a jury and they are matters that can not be adjusted to suit your purposes after the suit has been instituted. They are considerations that must be foremost in your mind in each day's work, because you never know in advance which case is going to be the source of this particular type of trouble.

There are other routine precautions which I am sure every doctor knows but which might be mentioned. They speak for themselves and need little comment:

(a) Procure written consents for operations.
(b) Be careful that your assistants are intelligent and qualified. As to duties you delegate to them, you will be responsible.
(c) Accept only patients whose ailments are well within your field of practice.
(d) Check the condition of your equipment frequently.
(e) If you are going away, make suitable provisions for the care of your practice.
(f) When you examine female patients, have a third person present, if possible.
(g) Finally, never let your patients know that you carry malpractice insurance.

So far, I have had in mind, the usual malpractice case in which no recovery can be had against a doctor unless some other doctor testifies in court that his treatment was below the standard required

continued on next page

by the law, that is, the standard of the average physician in the locality. I think I should point out, however, that there are cases in which a doctor can be sued successfully without any medical witness appearing against him. These are cases where the legal doctrine of *res ipsa loquitur,* (the thing speaks for itself) is applicable. The classic example might be put as follows: the plaintiff passing the defendant's brick building, on the roof of which defendant's employees are repairing a corner of a wall, is struck by a falling brick. These facts being shown, negligence on the part of the defendant is inferred and the burden is on the defendant to introduce testimony showing him free from negligence.

The doctrine has been applied to professional treatment in the following types of cases:

(a) sponges left in after an operation;

(b) slipping instruments; and

(c) burns from heating apparatus.

You can see that it is reasonable to require some explanation of these occurrences. I have had all three types (that list by the way is not exclusive) and I must say that I have never yet been able to devise an adequate explanation for the presence of sponges in a wound after an operation. An instrument conceivably may slip due to some outside cause and may be capable of explanation. A burn sustained by a person in full possession of sensations may not be indefensible because the fault may be the patient's for failure to complain; but the sponge in the wound is really difficult.

Passing by the obvious observation that these things should not happen, when they do happen, repair the damage as well as possible and get a report in to your insurance company or your lawyer and get the case adjusted, if possible. Cases of this nature should not be tried in court if such trial can be avoided by a reasonable settlement.

I mention this class of cases because they have been growing in recent years and there is an unpleasant tendency to enlarge the doctrine of *res ipsa loquitur.* Carried to the extreme it would mean that in every case where there was a bad result, a physician would be called on to explain why it was bad, without any negligence being proved against him.

There is another class of cases which I think merit special mention and in which the law is in some slight confusion. I refer to cases of sterilization.

As to nontherapeutic sterilization I can not conceive of any legal argument than can ever justify it, whether or not you have the consent of the patient and the patient's spouse. Nontherapeutic sterilization contains all of the elements of the crime of mayhem. It involves an intentional wounding, the severance of an organ and the destruction of a bodily function, none of which is necessary for the health or well being of the patient, and the result of which is to deprive the state of the reproductive facilities of one of its citizens, in which the state has a definite interest. Clearly, consent can not be given to a crime, and I am forced to the conclusion that nontherapeutic sterilization is a dangerous undertaking no matter how many consents you have.

As to therapeutic sterilization, however, assuming you have the consent of the patient, do you also need the consent of the spouse? Of course it is nice to have it, but if in some rare instance it is not forthcoming, why should you jeopardize the health of your patient? If a woman consented to the amputation of her gangrenous foot, which you recommended, would you refrain from operating because her husband objected? By all means obtain the consent of both wherever possible, but if you have a case where sterilization is clearly indicated for compelling reasons of health, I can not see why a spouse should be able to prevent it, if the patient consents.

Statistics pertaining to the number of malpractice cases instituted throughout the country are not, so far as I know, available in any accurate form. It is quite clear, however, that in the last two decades the growth of this type of case has been substantial. If we take as an index the number of cases reported in Appellate Courts, that is, cases that have gone to the Supreme Court of the various states, we find that one-third of all cases prior to 1940 were decided between 1930 and 1940. The problem, therefore, is a growing one, and it will be solved only by the affirmative action of professional groups. That action must take the form of a purposeful, educational campaign directed to every member of the profession designed to teach him to take care of himself. This can be done if the profession will acquire a thorough knowledge and understanding of its obligations, if it will develop the habit of attending scrupulously to the performance of those obligations and if it will have the common sense to take the precautions that I have mentioned.

PHYSICIANS SERVICE CLAIMS

In order to expedite claims made to Physicians Service the Joint Operations Committee offers the following suggestions to participating physicians:

1. Ask your patient if he is a subscriber to the R. I. Medical Society Physicians Service.
2. If a subscriber, ask to see the Membership Card.
3. Fill out the identification number.
4. Send in claim reports promptly.

LYMPHOID POLYPOID HYPERPLASIS OF THE RECTUM*

HERBERT FANGER, M.D. and BERNARD VIRSHUP, M.D.

The Authors. *Herbert Fanger, M.D., Pathologist, and Bernard Virshup, M.D., Junior Resident, Rhode Island Hospital, Providence.*

Introduction

THE occurrence of lymphoid tissue in the rectum is a well documented fact. It occurs frequently as solitary follicles, with well defined germinal centers, arising in the submucosa. Much more infrequent has been the report from time to time of rectal polyps which, for all practical purposes, are grossly indistinguishable from the ordinary rectal adenomatous polyp, but which on microscopic examination are found to be composed of collections of lymphoid tissue, hence the name lymphoid polypoid hyperplasia. It is the purpose of this paper to describe four such cases seen by us at the Institute of Pathology within the Rhode Island Hospital in the space of four months. Recognition of this condition is important since histologically it may be confused with malignant lymphomas.

Case Histories

1. The patient, D. M., is a 47-year-old white female admitted to the Rhode Island Hospital on April 27, 1949, who developed rectal bleeding, rectal itching, and constipation one month prior to admission. The blood was bright red and occurred as streaks on the surface of stools. On rectal examination a nodular area was felt at 6 o'clock. On proctoscopy this was described as a polypoid lesion, the pedicle of which could not be visualized, and which measured 2.5 cm. in diameter. This was covered with smooth mucous membrane. This polypoid lesion was biopsied and removed following the receipt of the pathological report.

2. The patient, E. W., is a 35-year-old white female who was seen in the Cancer Detection Clinic at the Rhode Island Hospital on February 25, 1949. There were no symptoms. Rectal examination, however, revealed a small polyp on the left posterolateral wall of the rectum. At operation a hard, sessile polyp, measuring 0.5 cm. in diameter and located about 9 cm. from the anus, was removed.

3. The patient, A. G., a 31-year-old white male, was admitted to the Miriam Hospital on January 21, 1949, with the chief complaint of slight bleeding from the rectum of nine years' duration. For a few months prior to admission, bleeding had become more frequent and more pronounced. On rectal examination internal hemorrhoids and two rectal polyps were noted. Of the two polyps, one was on a long stalk. The polyps were excised and hemorrhoidectomy was performed.

4. The patient, M. K., a 39-year-old white female, was admitted to the Memorial Hospital, Pawtucket, on March 9, 1949, with the chief complaint of bleeding from the rectum at irregular intervals for sixteen years. There had been several profuse hemorrhages. On rectal examination there were large external hemorrhoids in the anterior wall as well as a small polyp. The polyp was 1 inch in length and located 2 inches from the anorectal line anteriorly. It was removed with the hemorrhoids.

Pathology

Of the five polyps removed in these four cases, two had a broad base, one was attached by a thin stalk, and in two the base was not mentioned. Each was covered with smooth, pinkish gray, glistening mucous epithelium. In no case was their gross appearance characteristic of anything besides an adenomatous polyp.

Microscopically, these polyps in each case presented a similar picture. Sections revealed marked lymphoid hyperplasia of the submucosa with consequent polypoid elevation of the overlying mucosa. The cytology of the lymphocytes did not appear abnormal; the nuclei were dark, the chromatin coarsely granular, and the cytoplasm clear and sparse. The lymphocytes were arranged in numerous discrete follicles, with active germinal centers, showing phagocytic activity. The lymph follicles were of variable size, at times quite large, and in many instances of irregular shape. In addition, there was moderate lymphocytic infiltration of the mucosa to a varying degree.

Discussion

From time to time papers have appeared in the literature describing the occurrence of these polypoid tumors of the rectum, which have been classed as lymphoid polypoid hyperplasia. In 1948 *Li* briefly tabulated twenty-three cases reported since 1890 and added twenty-six others. Since then *Hel-*

continued on next page

*From the Institute of Pathology within the Rhode Island Hospital. The authors acknowledge with thanks the permission of Drs. Edward V. Famiglietti, Thad A. Krolicki, Daniel V. Troppoli, and Eske K. Windsberg to report these cases.

wig reported on seventy cases from the Army Institute of Pathology and *Heller* reported nine cases. These lesions, therefore, while not common, are undoubtedly not as rare as their absence from the standard textbooks would lead one to believe.

The nature of these lesions is invariably not at first suspected; their symptom complex does not differ from other common rectal lesions, and their gross appearance closely simulates adenomatous polyps of internal hemorrhoids. It is not until microscopic sections are taken that their lymphoid nature becomes apparent. As has been stated, lymph follicles are commonly observed in the rectal submucosa, and it seems logical to assume that the lymphoid accumulations we are observing are derived from these follicles. In each case, however, the important consideration is whether this multiplication of lymphoid tissue is a malignant or benign process. In the present series of cases we are impressed by the tendency to phagocytic activity of the cells within the follicle, the finding of follicles with germinal centers, and the focal nature of the lesion. The lymphoid tissue is, for the most part, limited to the submucosa and mucosa. In addition, both small and large lymphocytes are intermingled. These are features which are more consistent with a chronic inflammatory condition.

Our own feeling, therefore, is that these polypoid structures are a response to chronic inflammation with resultant lymphoid hyperplasia. This increase of lymphoid tissue has produced elevation of the mucosa with consequent polyp formation. Lymphoid polypoid hyperplasia is therefore a benign condition, and with removal no further sequelae need be anticipated.

In conclusion, however, we feel it necessary to point out that in certain cases the differentiation from the malignant lymphoma group may be extremely difficult, and that in these cases the best interest of the patient will be served by a careful program of postoperative observation.

Summary

Four cases of benign lymphoid polypoid hyperplasia are presented. This condition grossly resembles rectal polyps, and microscopically is composed of lymph follicles. The condition is benign, and is believed to represent an inflammatory condition. It must, however, be carefully differentiated from the malignant lymphoma group.

BIBLIOGRAPHY

Greenwáld: Am. J. Med. Soc., 203:823, 1942.
Li: Surg., 23:814, 1948.
Helwig: Am. J. Path., 25:793, 1949.
Heller: Am. J. Path., 25:794, 1949.
Bailey's Textbook of Histology, p. 464, 1944.



Lymphoid polypoid hyperplasia of anorectal region

SKIN IRRITATION AROUND THE ANUS DUE TO AUREOMYCIN

HENRY L. C. WEYLER, M.D.

The Author. *Henry L. C. Weyler, M.D., of Providence. Visiting Physician and Associate Cardiologist, Rhode Island Hospital; Cardiologist, Providence Lying-In Hospital.*

ATTENTION is being called to a complication that occurs with the use of Aureomycin that is not generally recognized as being caused by this drug. During the past year, a number of patients have been observed who received Aureomycin for various types of illnesses, including virus pneumonia, colds, chronic undulant fever, and genito-urinary tract infections. Those cases which originally had gastro-intestinal disturbances, such as colitis and diarrhea, are purposely being omitted so as not to confuse the cause of the findings that are described.

About a week or ten days after beginning the use of Aureomycin (in some cases sooner), a number of people develop redness, irritation, itching, and fissure formation around and into the anus. In some, the irritation extends down the thigh a short distance and/or down to the scrotum. This may last from a few days to several months having a tendency to almost disappear only to recur again a few days later. There may be a loss of superficial tissue with "weeping" or wetness. Some patients scratch themselves until they bleed.

The size of the dose does not seem to be important. 250 mgs. every 8 hours for 3 or 4 days is sufficient to cause trouble.

Associated with the above condition around the anus, the patient may complain of soreness of the rectum and general gastro-intestinal disturbances, such as excessive gas, rumbling of the intestines, or diarrhea. These complications have been described before by others.

The patient, for some reason, does not always tell the doctor about the irritation around the anus. Possibly he believes it is something that will soon go away or he is embarrassed. He never seems to associate it with Aureomycin. Therefore it is often necessary to ask direct questions about these symptoms. The complication is very frequent. However, I cannot give an exact percentage of the cases involved.

The cause of the skin irritation described above is not clear. Two explanations are being offered: 1. allergy, 2. a changed intestinal bacterial flora. Aureomycin ointment was used on such an inflammatory area in one patient and the condition was not made worse. If anything, it appeared to help. This would seem to rule out allergy due to the drug as a direct cause of the reaction. Moreover, antihistamine ointment did not help much. Changed bacterial flora could cause an allergic reaction in itself, or an irritation due directly to bacterial products.

Various types of ointments have been tried but none of the usual simple ointments have done very much good, except to give some immediate relief. As time went by, the patients showed less severe recurrences.

This complication can persist for a long time and cause a great deal of discomfort.

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DIABETES DETECTION WEEK — 1949

Report of the Committee on Diabetes of the Rhode Island Medical Society

It is estimated that there are over a million undiscovered diabetics in the United States. The American Diabetes Association in cooperation with the State and County Medical Societies, is attempting to find these diabetics so that early treatment can be advised. To accomplish this, the week of October 10th through the 16th, 1949, was designated as Diabetes Detection Week. At the suggestion of the American Diabetes Association, the President of the Rhode Island Medical Society, Dr. Joseph O'Connell appointed a Committee on Diabetes in the Spring of 1949 to study the subject and to cooperate with the national organization in this work.

The Committee met on several occasions, formulated plans, and to the best of our ability these plans were set in motion.

Every Physician in the State Medical Society was contacted by letter and his cooperation enlisted. Letters were also sent to all physicians engaged in industrial work requesting that all employees under their care be checked for glycosurea and that the results be kept confidential. The Hospitals in the State, the Health Departments in the State and private laboratories were contacted and their cooperation obtained. In addition we were fortunate in enlisting the cooperation of the District Nursing Associations, various civic organizations, the Department of Education, some of the private schools, the press and the radio. The drug stores acted as collecting stations. The radio stations made spot announcements and the Providence Journal-Bulletin had an editorial and several articles throughout that week, including endorsements of the drive by the Governor and the Mayor.

The Ames Company of Elkhart, Indiana, donated 1,000 Clinitest Tablets free of charge. The Medical Society furnished material to schools, industrial plants and Nursing Associations requesting them.

Everyone in the State was offered the opportunity to be tested for glycosurea. The examinations were made gratis as a public service by the physicians, hospitals, health departments and private laboratories throughout the State.

The response was very satisfactory. The overall number of tests made was 7,320; number of positives 319, or 4.35%. The number of blood sugar determinations was 31. Patients found to have glycosurea were advised to contact their own physicians; industrial plants kept their reports confidential so as not to jeopardize the jobs of employees found to have diabetes.

The Committee wishes to make the following recommendations:—(1) That the Auxiliary of the Rhode Island Medical Society take an active part in future drives. That it assume responsibility for some of the publicity essential for the success of the drive by arranging talks before Parent-Teacher organizations, etc., and (2) That each County Medical Society appoint a Committee on Diabetes, the Chairman of which shall attend all meetings held by the Committee on Diabetes of the Rhode Island Medical Society, and to work in close cooperation with our Committee.

We feel that Diabetes Detection Week has been a real service to the public and that it is a step forward in improving the relationship between the medical profession and the general public.

Our sincerest thanks to all who made this week a success; the Governor, the Mayor, the medical profession in general, private laboratories, hospitals, health departments, the Providence Journal-Bulletin, local radio stations, and last but not least, Mr. John Farrell who gave so willingly of his time and experience which contributed so much to the success of the drive.

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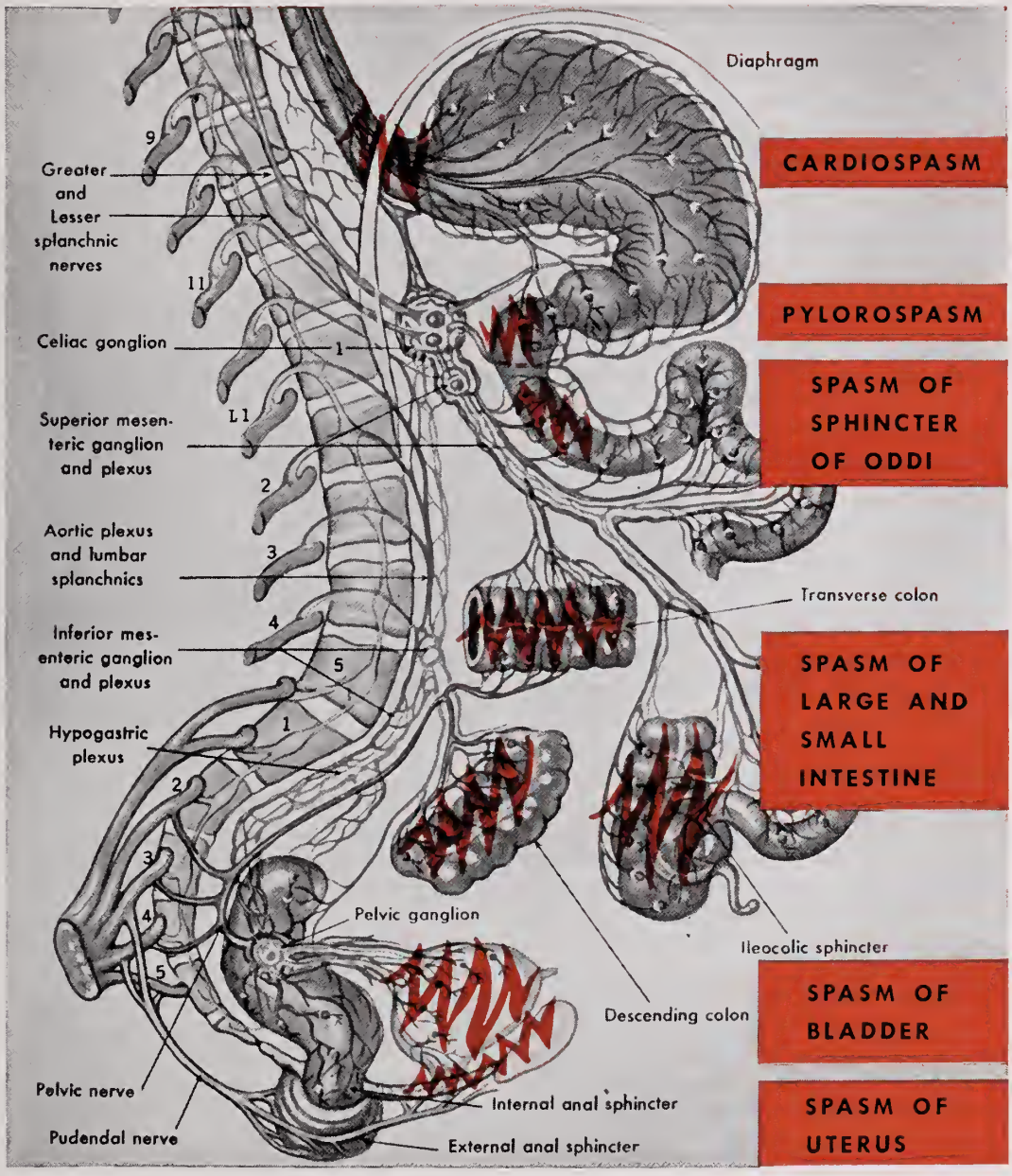
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REHABILITATION

REHABILITATION, a Mediterranean word, comes to us from the jurisprudence of the Middle Ages. To the medieval civil and canon lawyers, *rehabilitare* meant the act by which a man was restored to his former ability, of which he had been deprived by a conviction, sentence or judgment of a competent tribunal. Rehabilitation, therefore, denoted the *restoration* of something of which a man had been deprived, his good name, his status, his fortune, or his property. As in olden times, so today, when we speak of rehabilitation, there is implicit always in our meaning the idea of restoration. Indeed, so popular has the word become that we talk of rehabilitating the soil, our criminals, our finances and, on occasion, even literary reputations and political parties.

To us physicians the practice of medical rehabilitation is nothing new, although the word itself is a relatively recent addition to our vocabulary. From the earliest days of our craft, and because of it, we have always labored to rehabilitate our patients. As a practical art, medicine has ever been directed to the restoration of health, which means the "wholeness" of those committed to its care. The march of knowledge and the improvement in techniques have but widened our efforts and made them more effective over a wider field of endeavor—that is all. In our day we are required to participate in the solution of those multifarious and increasingly serious medical problems which are the inevitable concomitants of life in our industrial society. Whereas, for the most part, our forefathers in medicine were constantly at war with the ubiquitous microbe, we are confronted not by the microbe only, but by the ubiquitous machine.

Unless our attention has been directed particularly to the subject, few of us, perhaps, realize how vast is the army of those who need and desire rehabilitation. Drs. Howard Rusk and George G. Deaver have recently reminded us of some startling and sobering facts of which the following are a mere sample. The Baruch Committee on Physical Medicine estimates that there are 23,000,000 persons in the United States who are handicapped by reason of disease, injury, maladjustment or former wars. One person out of every 20 is disabled by sickness or accident in any 24-hour period. There were 19,000 amputations during the last war; in the same period there were 120,000 amputations in the civilian population. Approximately 1,500 service men lost their sight; during the same period 60,000 civilians were blinded. During the late war, 265,000 men were permanently disabled; in the same period, 1,250,000 men were permanently disabled in civilian life. It is estimated that there are 7,000,000 persons in the United States who are disabled by diseases of the heart and arteries; 360,000 by rheumatism, and over 2,000,000 by orthopedic troubles. In 1946, 10,000,000 disabling accidents occurred in this country, and of these, 370,000 resulted in permanent disability. There were 90,000 workers in the United States perma-

nently disabled because of industrial illness and over 2,000,000 other workers disabled temporarily. It is estimated that the total time lost by these men is equivalent to that of 1,000,000 workers kept out of work continuously for more than a full year. Again, it is estimated that spinal injuries alone cost the railroads of the United States approximately $50,000,000 annually and that $25,000,000 of this amount represents waste due to ineffective treatment.

Aside from the incalculable toll of suffering, unhappiness and domestic disintegration resulting from these conditions, the economic loss is tremendous. Faced with these irreducible and stubborn facts, it is not surprising that there is a growing interest in and demand for rehabilitation on the part of physicians and the general public, in a word, on the part of all those who are intent upon reducing this mass of misery.

Naturally, the purpose of rehabilitation is to make people self-supporting within the limits of their disabilities. There are many reasons, economic, social and spiritual, why it is desirable that the handicapped should not be totally dependent upon others. They, themselves, desire self-sufficiency; and the fact that they may attain this is evidenced by the work of the Federal Office of Vocational Rehabilitation. During the fiscal year 1949, 58,000 persons were rehabilitated. Seventy-four per cent were unemployed at the beginning of rehabilitation; 100 per cent had jobs when it was completed. The wages paid to these people reached $94,000,000, or almost 5 times the previous earnings of the entire group.

It should be remembered that the expense of vocational rehabilitation is not a continuing burden upon tax-payers. Once it is paid, the cost becomes merely a matter of history. What continues is the increasing economic worth, the improved wage- and salary-earning power of the beneficiaries. The gain in morale, of course, cannot be measured. It cannot be shown in statistical tables and charts and is best appreciated by those who are the recipients of rehabilitation.

Medicine has always been an individualistic profession. Indeed, it is about the only remaining individualistic profession in a cooperative world. But that successful rehabilitation is not a job for the physician only, should be obvious to anyone who gives the subject serious consideration. It requires, and should receive, the cooperative assistance of many people endowed with a variety of skills and experience in many fields; in a word, it demands team-work. In this team-work the physician should play an important part, for, to him, the sick and the injured look for help and guidance.

No man can be said to be fully rehabilitated until he is restored to the enjoyment of all the abilities he may possess. Too frequently, it happens that he is only partially rehabilitated when he is discharged from the hospital or leaves the office of the private practitioner. To stop rehabilitation at this point is to leave the job but half done; and it is becoming obvious already that the interest of physicians in rehabilitation, if somewhat tardy, is nevertheless increasing and that in the not distant future, they will take their place as leaders in this field of therapeutic endeavor.

POLLUTION

Corrupt and contented may have described the physical and mental attitude of Rhode Island a few years ago. Our waters stank, our shellfish died or were not fit to eat, much of our great bay was too nasty for respectable people to disport themselves there; smoke belched from most of our chimneys, obscuring the sun, discoloring the paint of our buildings almost as fast as it could be put on, begriming the inside of our habitations and the outside of our bodies, and slowly choking our foliage.

Few of the inhabitants seemed to be disturbed by this. Before the war a committee on water pollution tried valiantly to get some action but apathy defeated them.

Several years ago the Providence Medical Association appointed a committee on water pollution, later changed to a Rhode Island Medical Society committee. This Journal discussed the matter and public opinion began to bestir itself again. A new and active Pollution Abatement Committee of Rhode Island was formed, and the gentlemen at the State House got interested.

Things really are looking brighter now. Pictures and stories are appearing in the daily press telling of improvements.

Today we received from Harvey Flint, the Chairman of the Information Committee of the Pollution Abatement Committee of Rhode Island, a short word picture of the situation.

Woonsocket hasn't done much.

The Blackstone Valley authority is making great progress with $5,000,000 contracts let.

East Providence has voted to borrow $2,700,000 and construction will start in a couple of months.

Providence's million dollar disposal plant will be operating in two months and 60 million gallons a day of decent effluent will go into the bay instead of that much sewage.

Warren will be operating a modern plant by summer.

Bristol is fair.

continued on next page

We had quite a run in with the navy a year or two ago and they didn't like our mention of their nastiness. The Senate last week passed a bill for $1,234,000 for sewage disposal. Here's hoping.

Newport is expected to follow the Navy example.

Jamestown hasn't started yet.

Westerly is doing well but their Connecticut neighbor, Pawcatuck is dumping raw sewage. That's not neighborly.

East Greenwich isn't doing right by their quahaugs.

Pawtuxet River and Cranston are free of brewery waste and have stopped stinking.

The State Institutions will be handling their sewage properly by summer.

Industrial sewage from North of Providence is receiving attention. If more plants follow suit we may go through Market Square without clothes pins on our noses.

This really makes cheerful reading.

For several years the ' ovidence Medical Association has had a committe on Air Pollution. These men have worked hard in cooperation with other citizens and although not a great deal of concrete results have arisen as yet, a basis for good work has been laid down.

The city now has an Air Po. ition Engineer and we are hopeful that we will be able to go ahead as other cities have done.

St. Louis and Pittsburgh are striking examples.

It has been the feeling of those interested in this matter that the problem is more than a Providence one, and therefore, the Providence Medical Association committee is discontinuin its work which will be taken over by a committee of the Rhode Island Medical Society. There is a list in this issue of the committee appointments.

We are sure that the medical profession has been a great help in both these works, and we pledge our continued support.

MEDICAL-DENTAL SEMINARS

We are publishing in this issue of the Journal the program of the Medical-Dental Seminar which is to be conducted soon by the Rhode Island State Dental Society at Providence College. This is a continuation of the excellent work started last year when this same Society had a series of six lectures at Brown University given by eminent visiting physicians. Last year's lectures were received enthusiastically by a goodly number of dentists and we believe a smaller but appreciative group of physicians.

This work is highly to be commended and it has received the most genuine praise from our neighboring state of Connecticut. That is—they are imitating it. There is going to be this month a program at New Haven consisting of five lectures on mouth conditions. These lectures are sponsored jointly by the Connecticut State Medical Society and the Connecticut State Dental Association.

Probably in the past the average dentist has not known a great deal of general medicine and it is probably just as certain that the average physician has known mighty little about the significance of abnormal conditions within the mouth. Both groups cannot help being benefited if they will take interest in these coming series of lectures.

It is highly proper right here that we should pay a compliment to the forward looking attitude of the dental group in this state. Their annual meetings have been of a high character for years and they have an increasingly large number of their members who are demonstrating that they want to be much more than narrow specialists. It is difficult for a specialist to take wide views. We cannot help but feel that in our own profession it is much more difficult than in the past when nearly all our specialists came up through general practice.

We hope many of our members will increase their breadth of vision by attending this seminar on Medical-Dental relations at Providence College.

DIABETES WEEK IN RHODE ISLAND

The report of the Committee on Diabetes of the Rhode Island Medical Society which appears elsewhere in this issue of the Journal deserves comment from several points of view. In the first place, it illustrates what can be accomplished by the planned and concerted effort of many individuals and agencies in a program whose objective is to improve the health of the public. The testing of urine samples from over seven thousand individuals is no mean undertaking and the discovery of 319 positive specimens, or 4.35 per cent of those tested, is a result that indicates beyond a doubt that the whole program was justified in terms of definite benefit to a very appreciable number of individuals. Just how many of those whose specimens showed positive tests for sugar were known diabetics under treatment it is impossible to say. It is certain, however, that many of these, by the very fact of the testing and the general emphasis on the importance of careful control, will be stimulated to return for

a better regimen under medical supervision. Besides those known diabetics who have made the all too common error of straying from the straight and narrow path of conscientious care of their diabetes, there were of course many in whom the positive test proved on careful check by their own physicians to be evidence of minor or transient glycosurias of non-diabetic origin, or to be due to the presence in the urine of some reducing substance other than glucose. To these people too the tests were of some value.

When, however, we have eliminated from consideration the known diabetics and those with positive tests proved to be of non-diabetic origin, we still have left the group of people for whose benefit "Detection Week" was initiated, the previously undetected true diabetics. How many of them there are, cannot be exactly determined, but probably from 100 to 200 at least. To each of them the discovery of the disease in its early stages will definitely mean the possibility of a longer and happier life and of the avoidance of those complications that occur when diabetes is allowed to reach a serious stage before treatment is instituted.

May we not also add that this project, carried out in Rhode Island and throughout the country, by the medical profession and its co-workers; nurses, pharmacists and the various other agencies noted in the report, is evidence that practitioners of medicine are among those whose interests lie not solely in "feathering their own nests" as it has recently become so popular to assert, but also, as the success of this drive has demonstrated, in putting forth considerable effort, individually and by collective planning, for the public good.

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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

Fifteen members attended the January 24, 1950 meeting of the Newport County Medical Society at the Newport Hospital. Dr. Philomen P. Ciarla, president, opened the meeting at 9:05 P.M.

The minutes of the previous meeting were read.

Dr. Samuel Adelson moved that the letters of condolence, prepared by Dr. Norman MacLeod, on the late Drs. Eugene A. McCarthy and John A. Young be spread on the minutes of this meeting and similar letters signed by the President and Secretary of the Newport County Medical Society and the President and Secretary of the Staff of the Newport Hospital be sent to the widows of these men. The letters follow:

Dr. Eugene A. McCarthy was selected to organize the Orthopedic Clinic at the Newport Hospital in 1913. He has continuously served this Clinic and this community since that time.



HENRY W. BROWNELL, M.D.
President, 1950
THE NEWPORT COUNTY MEDICAL SOCIETY

He has always maintained a high degree of skill and was alert in adopting the new procedures in his specialty.

He has also been a faithful member of the Newport County Medical Society.

The Staff of the Newport Hospital regret the loss of Dr. McCarthy who was at all times ready to contribute his time and his talents to the service of this community.

The Newport County Medical Society will miss their former associate of more than thirty years.

* * *

Dr. John A. Young started practice in Newport in 1906. In the more than forty years that he has served this community he has been noted for his thoroughness, his courtesy, and his devotion to his patients.

His association with the Hospital started in 1916 and as a member of the Medical Service he has contributed much to the practice of Medicine. He has served as President of the Staff and for many years has been a member of the Board of Censors of the Newport Medical Society.

In all his activities he has been a faithful and conscientious Practitioner and has always cooperated in every effort to improve the care and treatment of the patients.

The Staff of the Newport Hospital will miss this sterling physician and the Newport County Medical Society has lost a friend and co-worker who was always ready to carry his share of any responsibility.

* * *

Dr. John Malone moved that the President appoint a Medical Advisory Committee of three members of the Newport County Medical Society to the Newport County Red Cross Blood Program; That Dr. William Freeman be appointed as Medical Consultant and that Mr. William Turner be appointed as Administrative Consultant to the Medical Advisory Committee of the Newport County Medical Society. This was seconded and passed. Drs. Alfred M. Tartaglino, Frank Logler, and John M. Malone were appointed by the President for this committee.

A revised application form to the Society was approved except for the inclusion of admission

continued on page 146



***"... the common cold is aborted or cured..."*[1]**

"... the common cold is aborted or cured when the allergic reaction is reversed before irreparable damage has been done to the respiratory mucous membrane."[1]

CORICIDIN

(antihistaminic—antipyretic—analgesic)

The chief constituent of CORICIDIN* is Chlor-*Trimeton** Maleate, probably the most potent antihistaminic in use today. Because of its extraordinary activity, Chlor-*Trimeton* is effective in remarkably small dosage—1/10 to 1/20 the dosage of other current antihistaminics. Side reactions, including drowsiness, are correspondingly rare. In addition to Chlor-*Trimeton*, CORICIDIN contains acetylsalicylic acid and acetophenetidin with caffeine, for analgesic and antipyretic effect.

Taken early, CORICIDIN is highly successful in favorably influencing the common cold. Even after the cold is established, CORICIDIN may reduce its severity and distress and help prevent spread of the infection by reducing sneezing.

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1. Brewster, J. M.: U. S. Nav. M. Bull. *49*:1, 1949.

*T. M.

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NEWPORT COUNTY MEDICAL SOCIETY

continued from page 144

fee which will be considered when our By-Laws are revised this year.

The applications for membership of Drs. John E. Carey and Lorenzo Orlando were accepted and approved.

Dr. Samuel Adelson suggested that the Secretary write to the Secretary of State to determine if this Society is listed as a Corporation.

Dr. Samuel Adelson commented on Dr. Michael Sullivan's long service in Medicine and moved that the President appoint a committee of three with full power to arrange for a testimonial dinner in the near future to honor Dr. Sullivan's 50th year out of Medical School—his 49th in practice. Dr. Logler seconded and this was carried.

Dr. Henry Brownell moved that a one year subscription be taken to Marjorie Shearons "American Medicine and the Political Scene", and that this be presented to the Newport Hospital Library. This was seconded and passed.

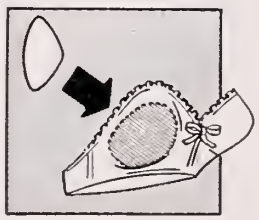
The following men were elected to office for 1950.

President:	Dr. Henry W. Brownell
1st Vice President:	Dr. Robert L. Bestoso
2nd Vice President:	Dr. John M. Malone
Secretary:	Dr. Osmond Grimes
Treasurer:	Dr. Norbert V. Zielinski
Delegates:	Dr. Donald B. Fletcher
	Dr. Frank J. Logler
Councillor:	Dr. Samuel Adelson
Alternate Councillor:	Dr. Osmond Grimes
Censors:	Dr. Norman M. MacLeod
	Dr. George A. Eckert

The guest speaker, Charles Millard, M.D. of Barrington, R. I., spoke on the "Academy of General Practitioners" following which there was a considerable period of spirited discussion. Collation followed.

Respectfully submitted,
JOHN M. MALONE, M.D., *Secretary*

in POST MASTECTOMY



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PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held on January 19, 1950, at 6:30 p.m. in the Nurses' Dining Room of Memorial Hospital. It was a supper meeting and twenty-three members were present.

The meeting was called to order by the President, Dr. John Gordon. The Secretary read the minutes of the previous meeting.

Dr. Robert Henry reported on the recent meeting of the House of Delegates during which physician directors of the Rhode Island Medical Society Physicians Service were nominated. Two members from the Pawtucket Medical Association, Dr. Earl Mara and Dr. Charles Farrell, were subsequently elected to the Board.

Dr. Charles L. Farrell, spoke briefly about the surgical-medical plan.

The meeting then adjourned to the Nurses' Auditorium where the speaker of the evening, Dr. Edwin B. Gammell, addressed the group on the subject "Hoarseness—Causes and Treatment." At the end of his talk Dr. Gammell presented a colored film depicting laryngeal lesions in an unusually lucid and satisfying demonstration, following which he introduced three of his patients on whom he had performed laryngectomies for Carcinoma. Listening to these patients with their esophogeal tones was a new experience to most of those present.

Dr. Rudolph Pearson of Providence spoke at some length about the speech classes held at the Rhode Island Medical Society Library. He also reported the encouraging results obtained in this type of lesion.

The meeting adjourned at 9:15 p.m.

Respectfully submitted,
KIERAN W. HENNESSEY, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, February 6, 1950. In the absence of the President, Dr. Ubaldo E. Zambarano, the meeting was called to order by Dr. Frank W. Dimmitt, Vice President, at 8:35 p.m.

The reading of the minutes of the previous meeting was omitted by consent of the members present.

Dr. Dimmitt reported a communication from the Medical Bureau of the Association calling to the attention of the members the fact that the new telephone directory would close within the month and therefore anyone desiring to have alternate listing with the Bureau should act promptly in the matter.

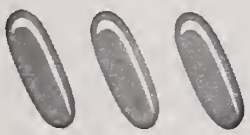
Dr. Dimmitt introduced as the first speaker of the evening Mr. S. Everett Wilkins, counsel for

continued on page 148

For the weary old woman of 21



SHE comes to you with marked pallor, complaining of chronic fatigue, no appetite. Her blood picture will probably reveal iron deficiency anemia, and judging by her lack of appetite and general condition you may suspect a concurrent vitamin deficiency. ● In such cases, isn't it more convenient and economical to correct both deficiencies with a single preparation? Just three IBEROL tablets, one with each meal, supply 210 mg. elemental iron plus generous amounts of ascorbic acid, vitamin B complex and liver concentrate. Yet, in spite of such potency, IBEROL tablets are compact and easy to swallow. The triple coating makes this possible—Abbott employs the ferrous sulfate itself as one of the coatings, thus reducing bulk and separating the iron from vitamins with which it is not compatible. Abbott



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Thiomine Hydrochloride ..... 6 mg. (6 x MDR*)
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Nicotinomide.. 30 mg. (2 x RDA†)
Ascorbic Acid, 150 mg. (5 x MDR*)
Pyridoxine Hydrochloride.. 3 mg.
Pontothenic Acid..... 6 mg. (os Colcium Pantothenote)
Folic Acid..... 5.1 mg.
Liver Concentrote, N.F.... 1.5 Gm.

*Minimum Daily Requirement
†Recommended Daily Dietary Allowance

Iberol® TABLETS

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Without Folic Acid **MACRON* TABLETS**

have the same potent formula as Iberol. but with the folic acid omitted

*TRADE MARK

PROVIDENCE MEDICAL ASSOCIATION

continued from page 146

the Aetna Casualty and Surety Company, who gave a most interesting talk on "Legal Hazards of the Practice of Medicine." Dr. Roland Hammond, Chairman of the Medical Grievance Committee of the State Medical Society discussed Mr. Wilkins' paper. (The address by Mr. Wilkins is published in its entirety in this issue of the MEDICAL JOURNAL.)

The second speaker of the evening was Dr. Edward Scott O'Keefe, Pediatrician, Union Hospital, Lynn, Massachusetts, who spoke on "The Importance of Diet in the Treatment of Diarrhea in Infants." Dr. O'Keefe's paper was discussed by Dr. William P. Buffum and other members of the Association. (Dr. O'Keefe's talk is published in its entirety in this issue of the MEDICAL JOURNAL.)

Prior to adjournment at 9:55 p.m. Dr. Francis Chafee presented a motion that the Association extend its best wishes to its President, Dr. U. E. Zambarano for a speedy convalescence and early return to Providence, and the hope of the Association that he will be able to attend the next and succeeding meetings of the Association. The motion was seconded and unanimously adopted.

Attendance 88.

Collation was served.

Respectfully submitted,

JOHN E. FARRELL, SC.D., *Executive Secretary*
in the absence of
DANIEL V. TROPPOLI, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kent County Medical Society was held on Tuesday, January 17th at 1515 West Shore Road.

The meeting was called to order at 9:15 p.m. by President Dr. Joseph C. Kent.

The minutes of the last meeting were accepted as read.

Dr. John Mack, treasurer of the Society submitted a written annual report which was read to the members by the secretary. Dr. George Young moved that this report be accepted; seconded by Dr. Hardy and it was so voted.

Dr. George Young then reported that he accompanied Dr. Orland Smith to the local V.F.W. Post to talk to their members concerning the need of establishing a blood bank at the new Kent County Memorial Hospital. Considerable enthusiasm was rendered and support attained for this project. Dr. Young stated that a "spark was started" and will report on the progress at a later date.

It was also reported that the Warwick Kiwanis Club was interested in contributing some item; suggestion of an incubator was mentioned.

Application for membership from Dr. Russell Hager of 8 Post Road was received and approved by the board of censors. Vote taken and it was then moved by Dr. Taggart that the secretary cast one ballot; this was seconded by Dr. Hardy.

Following the business meeting, Dr. Rudolph Pearson was then introduced by the president. He delivered a very informative review of the etiology and management of "Headaches."

The meeting adjourned at 10:30 p.m.

Respectfully submitted,

E. T. HACKMAN, M.D., *Secretary*

CORRESPONDENCE

To The Editor:

I believe it is not generally known by the medical profession that there is a movement afoot to close Lakeside. This venerable institution which has served the community for many years is about to suffer because of insufficient operating funds from the Community Chest. Over its many years Lakeside has served as a convalescent home for underprivileged and malnourished children. For much of its existence, its activity was guided by the Providence Tuberculosis League. During this time the underprivileged and malnourished children of tuberculous parents were the principal beneficiaries of its activity. More recently underprivileged and malnourished children of many types and in increasing numbers were admitted. The community will sorely miss the benefits of this necessary institution. If Lakeside does pass from the scene and this is the most likely result, some similar institution must be erected to fulfill the part which Lakeside has played. In spite of all of our good health procedures this community now and for many years will have underprivileged and malnourished children in need of convalescent supervision in a "Lakeside".

I would like to call upon Rhode Island physicians to express their views of the Lakeside closing.

PETER F. HARRINGTON, M.D.

IN PAWTUCKET IT'S . . .

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(Combination Spray and Dropper)

Clinical and laboratory tests have proven:

NO rise in bloodpressure
NO rapid pulse
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SUPPLIED: 30 groms (1 fl oz.) in Dohony Sproy-O-Mizer (Combination Sproy and Dropper). *Also for Doctor's office and Hospital use—in Pint bottles.*

FOR TOPICAL APPLICATION — INDICATIONS include: comman cald, allergic and hypertrophic rhinitis, sinus infectians; for pre and post-operative shrinkage of nasal mucosa; as a diagnostic oid in office procedures. **ESPECIALLY SUITABLE FOR INFANTS AND CHILDREN.**

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BY-LAWS OF THE RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

(As Amended)

Article I
Membership of the Corporation

Section 1. The members of the Rhode Island Medical Society Physicians Service shall consist of (a) members of the House of Delegates of the Rhode Island Medical Society (as the same shall be from time to time constituted), (b) the incorporators of the Rhode Island Medical Society Physicians Service, (c) members of the Board of Directors of the Rhode Island Medical Society Physicians Service (as the same shall be from time to time constituted), and (d) such other persons, non-physicians, as may be elected to membership in the corporation by its Board of Directors; provided that non-medical members shall not constitute more than twenty per cent of the total membership of the corporation.

Section 2. Each member of the corporation shall be entitled to one vote.

Article II
Meetings

Section 1. The annual meeting of the members of the Rhode Island Medical Society Physicians Service shall be held in the month of January of each year on a day fixed by the Board of Directors, and at such place as the Board of Directors shall designate.

Section 2. Special meetings of the members may be called at any time by the President, and shall be called by him on written request of a majority of the directors or one third of the members of the corporation.

Section 3. Written notice of each meeting shall be mailed to the members at least five days, or telegraphed or delivered to each member at least forty-eight hours before the day appointed for the meeting at their last known address on the records of the corporation.

Section 4. At every meeting of the members there shall be represented in person at least twenty of the members to constitute a quorum, but a smaller number may adjourn from time to time.

Article III
Board of Directors

Section 1. The incorporators and such persons as they shall elect shall serve as the directors until the annual meeting of the members in January, 1950, at which time the Board of Directors shall be constituted as follows: Twelve Fellows of the Rhode Island Medical Society shall be nominated by the House of Delegates of said Society, four to hold office for a term of three years, four to hold office for a term of two years, and four to hold office for a term of one year, and thereafter annually four Fellows of the Society shall be nominated by the House of Delegates to hold office for a term of three years. Six directors, of whom two shall be nominated by the Hospital Service Corporation of Rhode Island, elected annually by the Board of Directors of the Rhode Island Medical Society Physicians Service to hold office until the next succeeding annual meeting of the members of the Rhode Island Medical Society Physicians Service, as representatives of the public.

Section 2. The Board of Directors shall have the power to select persons to fill vacancies in the Board, occurring during the year, who shall serve until the next annual meeting of the members.

Section 3. The Board of Directors shall have supervision and control of the business, property, affairs and management of the corporation, and without limiting the generality of the foregoing, shall elect the officers of the corporation; shall have authority to make rules and regulations for the conduct of affairs of the corporation, to decide the scope of services to be furnished subscribers and any conditions thereof, to adopt rates and indemnity schedules and enter into contracts for the rendering of all such services, to incur indebtedness in such amounts and under such terms and conditions as it shall deem necessary and proper, to invest and reinvest all money, funds and securities of the corporation, to create and conserve a reserve fund to be used for promoting the purposes of the corporation, and to delegate its powers to committees, officers, agents and representatives; and shall have such other powers as may be necessary or expedient to carry out the purposes of the corporation. The Board of Directors may employ such persons as it may deem necessary to assist the officers and the board to carry on the work of the corporation.

Section 4. The Board of Directors shall hold an annual meeting following the annual meeting of

continued on page 152

A New, Distinctive Synthetic ANTISPASMODIC

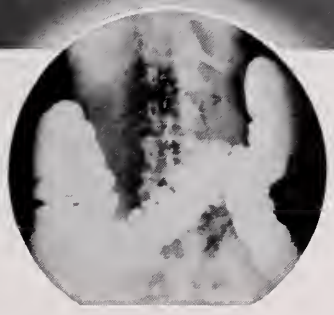
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HIGHLY POTENT . . . NON-TOXIC

DUAL ACTIVITY



X-ray, typical spastic gut



X-ray, typical normal gut

THE THIOL LINKAGE, **chemically incorporated for the first time in a synthetic antispasmodic drug, is responsible for the extremely high potency of Trocinate.**

TROCINATE (Beta-diethylaminoethyl-diphenylthioacetate hydrochloride) offers in a single molecule *all* the advantages and *none* of the disadvantages of atropine and papaverine. Note these outstanding properties:

1. *Strong musculotropic action*
2. *Strong neurotropic action*
3. *Non-narcotic*
4. *Remarkably free from side-effects, low in toxicity*

Professional samples are available. Write Wm. P. Poythress and Company, Incorporated, Richmond 17, Va.

INDICATIONS: For the relief of smooth muscle spasm; as existing in pylorospasm, gastric hyperacidity, gastric or duodenal ulcer, gastritis, enteritis, colitis, irritable colon, biliary colic, biliary dyskinesia.

DOSAGE: Adults—one or two tablets, three or four times a day. (Swallow whole to avoid local anesthetic effect).

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Trocinate with phenobarbital (red sugar-coated tablets) contains 65 mg. Trocinate and 15 mg. phenobarbital. Available in bottles of 40 and 250 tablets.

POYTHRESS *Trocinate* Beta-diethylaminoethyl-diphenylthioacetate hydrochloride

BY-LAWS, R. I. PHYSICIANS SERVICE
continued from page 150

the members of the corporation, or any special meeting of the members held in lieu thereof. Regular meetings shall be held at such times and places as the board shall determine. Special meetings may be called at any time by the President, and shall be called by him on written request of at least one third of the directors.

Section 5. A majority of the directors shall constitute a quorum for a meeting of the Board of Directors. If at any meeting less than a quorum shall be present, a majority of those present may adjourn the meeting from time to time without notice. The action of a majority of the directors present at any meeting at which there is a quorum shall constitute the action of the Board of Directors.

Section 6. No compensation shall be paid to any director for services as director, but reimbursement for actual and reasonable expenses may be authorized by the Board.

Article IV
Committees

Section 1. The Board of Directors shall appoint annually four (4) standing committees—an Executive Committee, a Finance Committee, a Professional Advisory Committee, and a Joint Operations Committee. It may appoint such other committees as it may deem appropriate.

Section 2. The Executive Committee shall be composed of (5) directors. Three (3) members shall constitute a quorum of this committee. The Executive Committee shall be vested with such powers of the Board of Directors when the board is not in session as the board shall by resolution provide. It shall make a written report of its proceedings and action at the next succeeding meeting of the Board of Directors.

Section 3. The Finance Committee shall consist of three (3) directors. It shall have such financial duties and powers as may be given to it by the Board of Directors. One member of the Executive Committee shall be a member of the Finance Committee. The Finance Committee shall make a report of its transactions at the next succeeding meeting of the Board of Directors or Executive Committee.

Section 4. The Professional Advisory Committee shall consist of three (3) directors. In accordance with the general policy of the corporation and subject to the authority of the Board of Directors and the Executive Committee, the Professional Advisory Committee shall supervise arrangements with physicians concerning participation, fees, and the rendering of services according to the provisions of the medical service plan, and its determinations shall be binding and conclusive on the persons concerned. One member of the Executive Committee shall be a member of the Professional Advisory Committee.

Section 5. The Joint Operations Committee shall consist of three (3) directors. It shall carry out the functions set forth in the joint operations agreement between the Rhode Island Medical Society Physicians Service and the Hospital Service Corporation of Rhode Island, and such other functions as may be delegated to it from time to time by the Board of Directors. It shall make a written report of its proceedings and actions at the next succeeding meeting of the Board of Directors, or the Executive Committee.

Article V
Officers

Section 1. The officers of the corporation shall be elected annually by the Board of Directors and shall consist of a President, a Vice President, a Secretary, a Treasurer, and such Assistant Treasurers and Secretaries as the Board of Directors may deem appropriate. All of the said officers shall hold their respective offices for one year and thereafter until their successors are elected and qualified, except that the officers appointed at the first meeting of the corporation shall hold office until the first annual meeting and thereafter until their successors are elected and qualified. The President shall be chosen from among the directors of the corporation, but other officers need not be. The board may appoint such other officers and agents as it may deem necessary for the transaction of the business of the corporation, and all such officers and agents shall respectively have such authority and perform such duties as may be prescribed by the Board of Directors. Officers and agents may be paid such reasonable salaries or compensation as the Board of Directors shall determine.

Section 2. The President shall preside at all meetings of the members of the corporation and the Board of Directors; shall perform such duties as are required by law or which usually pertain to such office; and shall exercise such other powers and perform such other duties as may be assigned to him by the Board of Directors.

Section 3. The Vice President shall perform such duties as may be assigned by the Board of Directors, and he shall exercise the powers and perform the duties of the President in the absence or incapacity of the President.

Section 4. The Secretary shall record the minutes of all meetings of the members of the corporation and the Board of Directors; shall have the custody of the corporate seal, and in all proper cases shall affix the same to any instrument requiring the seal. The Secretary shall attend to the

continued on page 154



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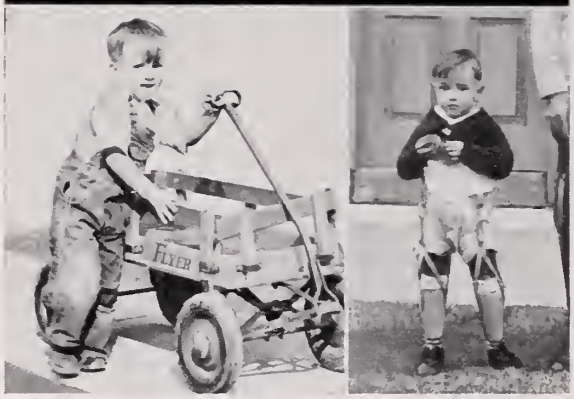
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continued from page 152

giving and receiving of all notices of the corporation, and shall perform such other acts as the Board of Directors may determine.

Section 5. The Treasurer shall have the care and custody of and be responsible for the funds and securities of the corporation. He shall direct the deposits in such bank or banks as the Board of Directors may designate, and shall disburse the funds in such manner as may be designated by the board. He shall keep proper vouchers and a complete record of receipts and disbursements. He shall make an annual report in writing on the finances of the corporation, and he shall make such other reports as may from time to time be required by the Board of Directors. He shall, if required by the Board of Directors, give bond in such form, in such sum and with such sureties as it may require.

Section 6. The Executive Director shall, under the direction of the Joint Operations Committee and the Board of Directors of the Rhode Island Medical Society Physicians Service, carry on the business of the corporation pertaining to all administrative functions as set forth in the joint operations agreement between this corporation and the Hospital Service Corporation of Rhode Island. He shall make such reports and attend such meetings as may be required by the Board of Directors.

Article VI
Execution of Papers

Except as the Board of Directors may generally or in particular cases authorize the execution thereof in some other manner, (1) all conveyances of real estate and leases shall be signed by the President or Treasurer; (2) all obligations for payment of money on sight, including checks and drafts, made or endorsed by the corporation, except when endorsed for deposit or collection, shall be signed by either the Treasurer or Assistant Treasurer; (3) all other obligations for the payment of money and all evidences of debt payable at a future time, including acceptances, notes and bonds, shall be signed by the Treasurer, and countersigned by either the President, Secretary or Vice President; and (4) no person holding more than one office in the corporation may sign, countersign or execute any paper in the capacity of more than one office so held in cases where two signatures are required.

Article VII
Subscribers

Section 1. Persons who respectively fulfill the qualifications specified by the Board of Directors shall be eligible as subscribers to the respective medical service plans. The Board of Directors shall adopt medical service certificates embodying such

terms and provisions as are deemed appropriate. The Board may specify the limits of the benefits to be furnished and may classify such benefits.

Section 2. Employers, societies, groups and other authorities or agencies may underwrite or contribute in full or in part to the costs of medical care for the benefit of employees, members or other persons who may become entitled to medical service under a medical service plan.

Section 3. The corporation shall not in any event or under any circumstances be liable for any act, negligence or failure to act by a physician in connection with medical care or services given or that should have been given to any persons.

ARTICLE VIII
Participating Physician

Section 1. Any physician or surgeon who is licensed to practice medicine or surgery under Section 3 of Chapter 275 of the General Laws of Rhode Island (1938), and who shall agree with the corporation to abide by the rules and regulations of the corporation may become a Participating Physician.

Section 2. Subject to the code of ethics of the American Medical Association, a Participating Physician shall have the right to accept or reject patients so far as subscribers are concerned and the right to discontinue treatment of any subscriber according to the code of ethics of the American Medical Association, provided, however, he shall not have the right to refuse to accept a subscriber as a patient or to continue treatment of a subscriber for the reason that he is a subscriber, and such refusal shall constitute grounds for the termination by the corporation of its agreement with a Participating Physician.

Section 3. A Participating Physician shall not request or accept from anyone whom he knows to be a subscriber within the eligible income groups specified by income limits established from time to time by the corporation any compensation for such services as such subscriber is entitled to under his contract with the corporation, except such charges, if any, as may be provided in the rules and regulations adopted by the Board of Directors and set forth in the subscription certificate or contract.

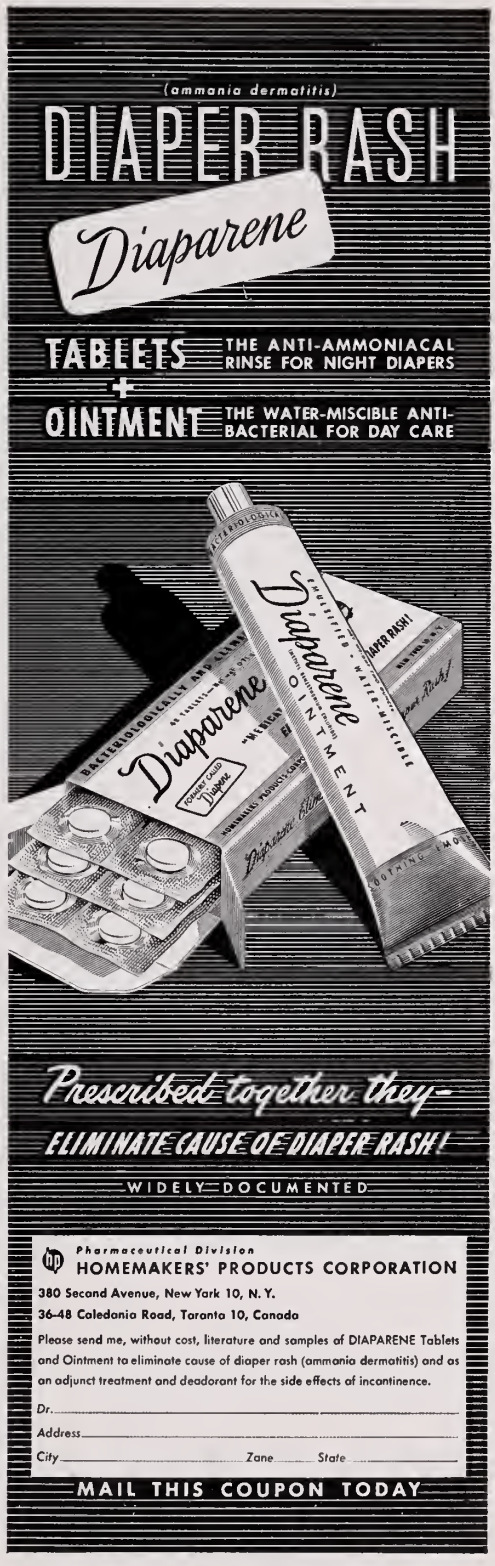
ARTICLE IX
Fiscal Year

The fiscal year of the corporation shall be the calendar year.

ARTICLE X
Miscellaneous

Section 1. The Board of Directors may adopt such rules and regulations as it may deem necessary,

continued on page 158



BOOK REVIEWS

MEDICAL STATE BOARD QUESTIONS AND ANSWERS. By R. H. Goepp, M.D. and Harrison F. Flippin, M.D. Eighth edition. Published by W. B. Saunders Company, 1950.

The eighth edition of this well-known and much utilized book on Medical State Board Questions and Answers appears to follow the style of the earlier editions.

Much additional material has been added to it, however, to keep it in line with the important contributions that have recently been made in the field of medicine, particularly in therapeutics.

In order to present the latest knowledge available Dr. Goepp secured the colaboration of Dr. Harrison F. Flippin, a physician especially well qualified by his clinical and teaching experience. With the exception of the section on anatomy which was completely revised in the preceding edition all sections have been rewritten and brought up to date and a new section on psychiatry has been added.

The new drugs and therapeutic procedures appear to be fairly well covered although in some instances it appears that more detailed descriptions would have increased the value of the book.

In spite of the fact that the Rhode Island Board of Examiners in Medicine does not obtain its examination material from this source, it appears that the book could serve as a valuable and useful means of review for candidates preparing for State Board examination.

JOHN A. BOLSTER, M.D., *Secretary*
State Board of Examiners in Medicine

OCCUPATIONAL MARKS AND OTHER PHYSICAL SIGNS: A GUIDE TO PERSONAL IDENTIFICATION. By Francesco Ronchese, M.D., Assistant Professor of Dermatology, Boston University School of Medicine, Boston. Cloth. Price $5.50. Pp. 181, with 151 illustrations. Grune & Stratton, Inc., 381 4th Ave., New York 16, 1948.

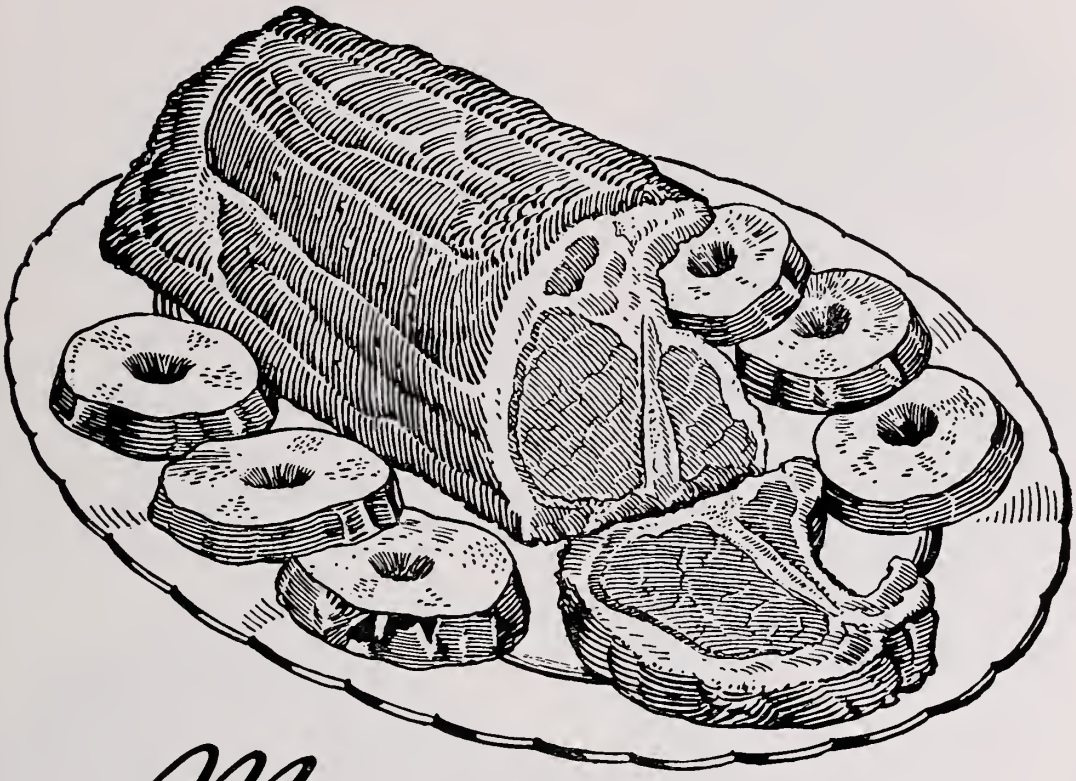
In his preface, the author states that the gathering of his data served "as a relaxation and welcome variation in the more routine aspects of practice." The reader of the composite of this data will, in turn, find it a relaxing and welcome variation from the more routine type of medical literature. Written in simple and straightforward style, and interspersed with humorous comments, it presents a verbal and pictorial account principally of those cutaneous marks characteristic of various occupations.

The book is divided into two main sections, the first descriptive and the second composed of photographs and sketches. The descriptive part is, in turn, divided into six chapters. The first briefly covers some general aspects of the subject and is essentially an introduction. The following section discusses specific occupational marks, ranging from the well-known "housemaid's knee" to the less familiar thin, painful calluses on the palms of glass blowers due to their holding heavy, hot, iron blowpipes. The chapter on professional markings reviews the characteristic findings among physicians, athletes, dancers and musicians. In the next section, distinctive markings are considered in terms of specific body areas. Of interest was the report that notching of the upper incisors, due to the habit of opening bobby pins with the teeth, is found in approximately 90 per cent of women. Pseudo occupation marks, that is, marks resembling those due to occupation but actually due to some other cause, and legal problems arising from them and from the true occupational stigmata are considered briefly. Examples, such as psoriasis of the knuckles resembling scrubwoman calluses, and a lesion of von Recklinghausen's disease in the center of one palm simulating a professional callus, are mentioned. A general classification of occupational marks on the basis of usefulness in personal identification is presented in the final chapter. The second main section, comprising two-thirds of the book, contains an excellent collection of photographs and sketches illustrating the marks referred to in the text.

Dr. Ronchese, as a result of many years of thorough and painstaking study of patients, has been able to gather a large series of occupational marks and other characteristic physical signs. Perhaps most frequently these were discovered solely as a result of the examination, the patient volunteering information only about the dermatosis elsewhere which was responsible for his seeing the author. Therefore, Dr. Ronchese emphasizes the necessity for a complete and careful examination of each patient, always viewing any observed mark in terms of the whole picture, and at all times being aware of the possibility of pseudo occupational stigmata.

This book, filled with a wealth of fascinating information, should prove of considerable interest to all physicians, to the criminologist, and to those concerned with the personal identification of the dead.

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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (Apr. 2,) 1949

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concluded from page 155

expedient or proper to further the purposes of the corporation.

Section 2. The Board of Directors is vested with the authority to interpret and construe these by-laws and any rules and regulations which may be adopted by the board.

Section 3. The seal of the corporation shall contain the words "THE RHODE MEDICAL SOCIETY PHYSICIANS SERVICE" and the date of its incorporation, and shall be in such form as the Board of Directors may determine.

Section 4. The principal offices of the corporation shall be in the city of Providence in the State of Rhode Island.

Section 5. These By-Laws may be amended or altered at any meeting of the Board of Directors by the affirmative vote of two-thirds of the directors present, provided notice of the general character of the proposed amendment or alteration was contained in the notice of the meeting.

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Paul K. Losch, D.D.S.

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TUESDAY, APRIL 11 . . . AT 7:30 P.M.

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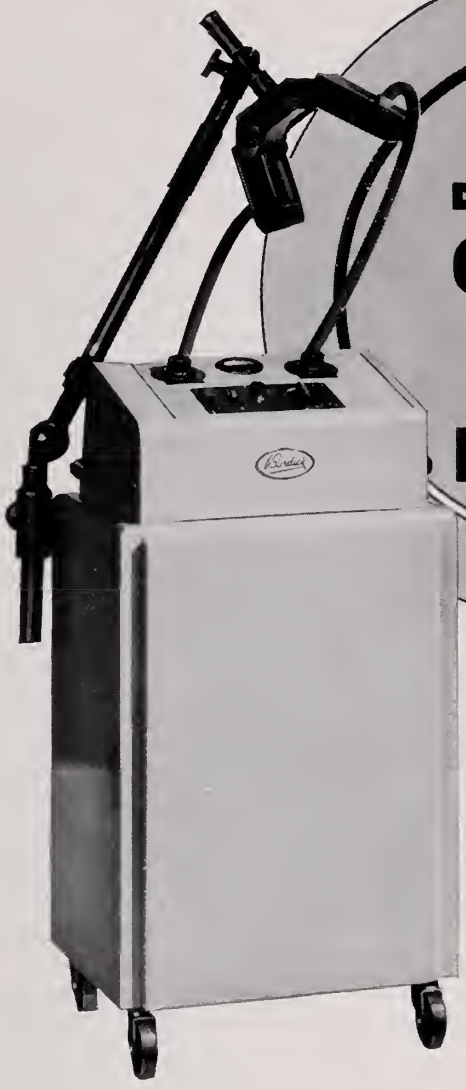


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(*See Page 192*)

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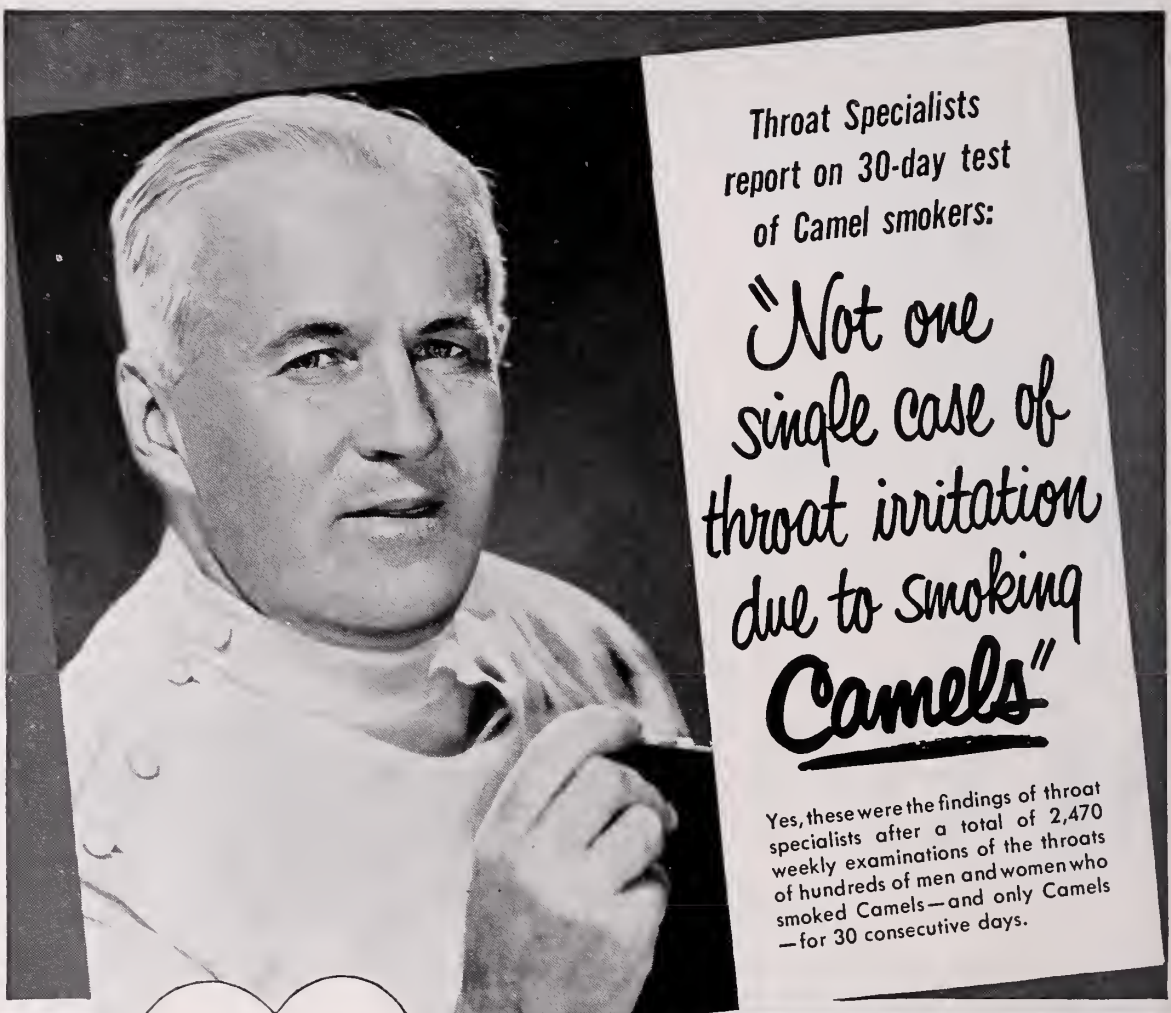
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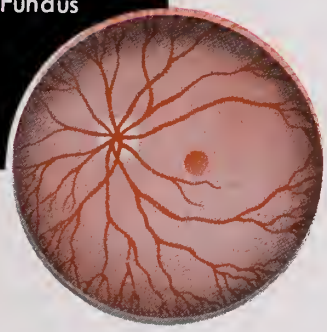
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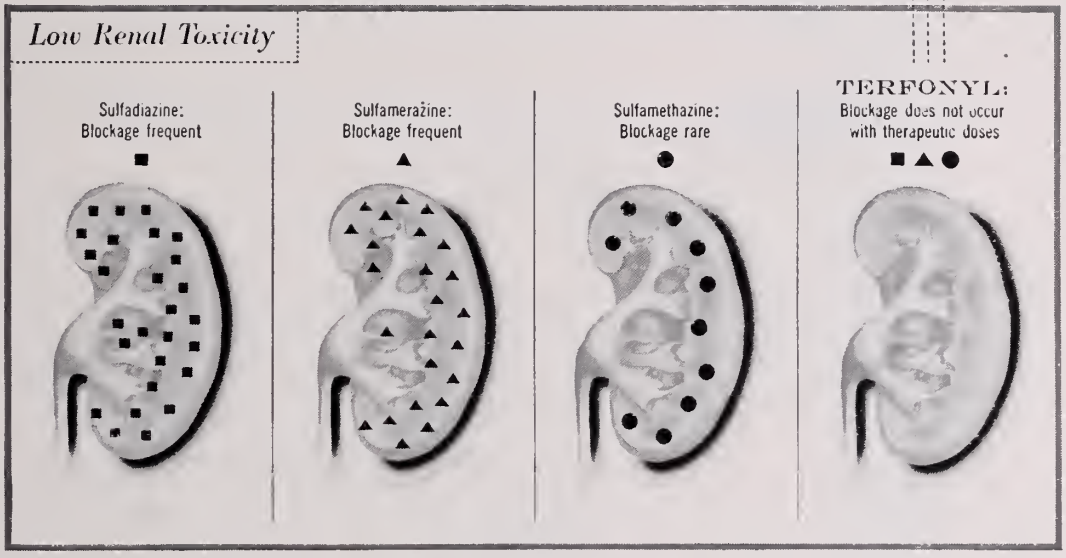
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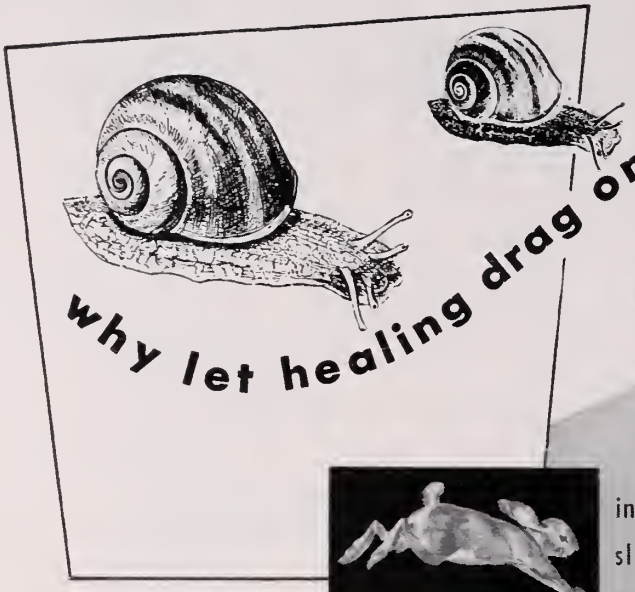
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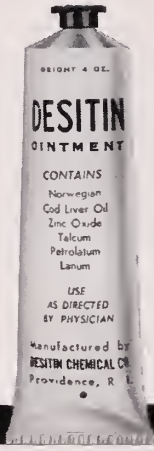
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1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Industrial Med. & Surg. 18:512, 1949.



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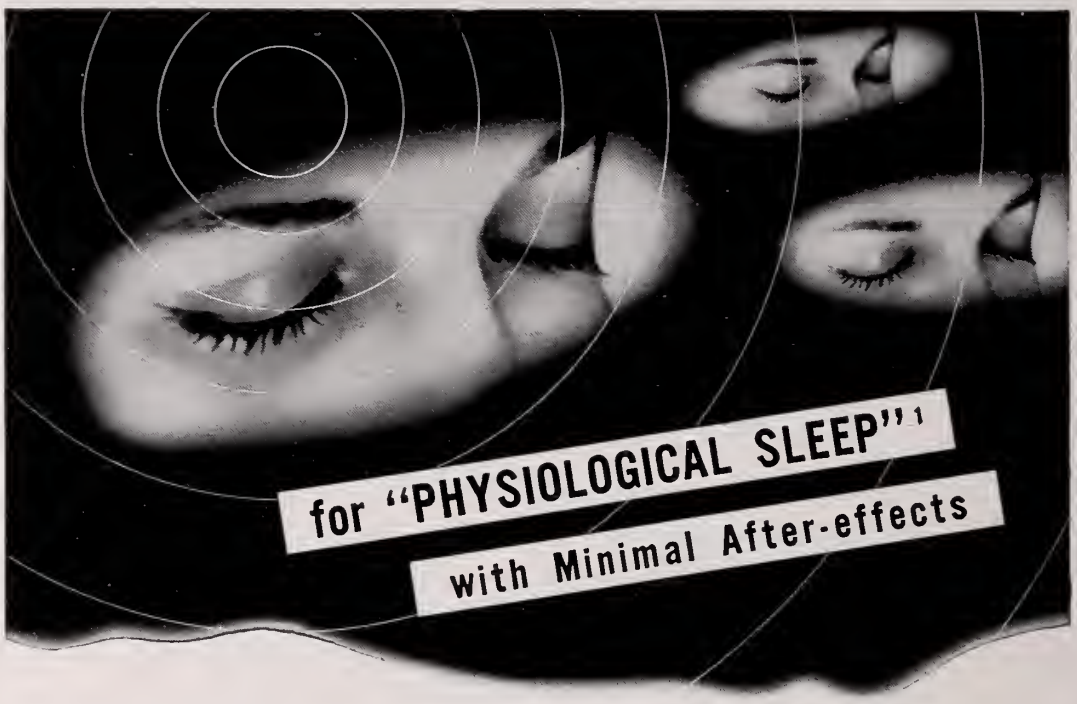
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXIII APRIL, 1950 NO. 4

THE TREATMENT OF PEPTIC ULCER*

FRANK GLENN, M.D., CLAUDE FORKNER, M.D.,
S. W. MOORE, M.D., and THOMAS P. ALMY, M.D.

The Authors. *Members of the Faculty of Cornell University Medical College: Frank Glenn, M.D., Professor of Surgery; Claude Forkner, M.D., Associate Professor of Clinical Medicine; S. W. Moore, M.D., Associate Professor of Clinical Surgery; Thomas P. Almy, M.D., James Ewing Associate Professor of Neoplastic Diseases.*

DR. FORKNER: *Introduction*

PEPTIC ULCER is one of the most important diseases with which internists and surgeons constantly are concerned. It afflicts, at some time or other, from five to ten per cent of the adult population. It is an acute or chronic, often incurable, recurrent disease of unknown etiology. Frequently peptic ulcer responds dramatically to adequate therapy but, owing to the intervention of many variable circumstances, peptic ulcer often recurs and may be associated with a variety of serious complications presenting difficult diagnostic and therapeutic problems.

In spite of our long familiarity with peptic ulcer, there still is much controversy and confusion with regard to its management. We shall attempt to bring together some of the more important aspects of management combining the medical, the surgical, and the psychosomatic approaches.

DR. ALMY: *Medical Therapy*

The usual state of gastric function in peptic ulcer is one of hyperactivity: Hypersecretion, hypermotility, and engorgement of the mucosa. The last point has been determined both by gastroscopy and x-ray. In studies by Wolf and Wolff on a man with a permanent gastric fistula (Tom), engorgement of the mucosa accompanied hypermotility and hypersecretion. Experimentally verified causes of this condition are: 1) Sight, smell, etc., of food (appetite juice); 2) Stressful life situations evoking resentment; 3) Alcohol, coffee; 4) Drugs: Histamine, prostigmine; 5) Tobacco. Of this group, only emotional tension and alcohol appear related to the onset and recurrences of ulcer, on the basis of clinically observed associations. This is the basis of our emphasis on emotional factors in the understanding of the clinical problem. There is a single experiment which indicates that the stomach of man does not react in a state of resentment if the vagus nerves have been severed.

In using these ideas in actual practice, simple psychotherapy is high on the agenda, and we have fond it feasible in this group of patients for the internist to do it without occupying too much time. Twenty to thirty minutes is added to the usual history for the taking of a simple, biographical, personal history; and events which coincided in time with the onset or recurrence of ulcer symptoms are earmarked for future discussion. Treatment begins as soon as the patient opens his mouth, with the release of some of his resentment as he tells his troubles, and with the feeling of confidence in and dependence upon his physician which develop as he realizes the interest of his doctor in himself as a person. Here we have the two principal tools of simple psychotherapy: 1) Ventilation of feelings, or catharsis, 2) Dependence upon physician, or transference.

The next step is intelligent alteration of the environment, the desirability of which is often obvious after half an hour's talk with the patient. Sometimes this is extremely difficult to achieve.

Usually it is not necessary nor feasible to send the patient to a psychiatrist. People with deeply buried emotional conflicts and those with paranoid trends should, however, be handled only by the psychiatrist.

I try to make these patients stop smoking by every means short of arguing with them. I think

continued on next page

*Presented at the John F. Kenny Annual Clinic of the Memorial Hospital Internes' Alumni Association, Memorial Hospital, Pawtucket, Rhode Island, November 10, 1948.

when a physician argues with a patient over this point, the harm is greater than the good one can do by having him stop. I would therefore compromise on a reduction in the amount, and permit smoking only after meals. Such a compromise is occasionally necessary even with coffee and alcohol, which I consider real dangers to the ulcer patient.

I regard further treatment as an adaption to the disturbed physiology of the stomach: 1) Hypermotility—need for frequent feedings, high fat; 2) Hypersecretion — need for high protein diet, alkali; 3) Engorgement—need for soft diet, free of peppers or condiments or other agents which might injure the mucosa. Our usual regimen includes a six feeding soft diet, pureed at first, with a nonabsorbable alkali such as aluminum hydroxide (often mixed with magnesium trisilicate) in doses of two teaspoonfuls or two tablets one hour after meals. I have the patient take milk-of-magnesia every night in doses sufficient to produce a daily soft stool.

When a patient has a history of recent night pain or pain in the early morning, I have him awakened and given milk every two hours. When this is not enough to relieve pain, the use of a slow intragastric drip of milk or dilute amphogel should be considered.

The old Sippy regimen—hourly feedings of milk and cream plus Sippy powders—is valuable for rapid control of an active ulcer, but has two serious disadvantages; it is inadequate in protein (35 gm./day), iron, and vitamins; and the alkali is absorbable and may induce alkalosis. For these reasons I would not use it except with the patient under almost daily observation.

The secretion of HCL in large amounts, tends to produce an alkali excess in the blood, which is usually compensated in part by absorption of chloride lower in the intestine. When severe vomiting occurs, however, as in obstructed ulcer, chloride is lost to the body and serious alkalosis may develop.

Weakness and anorexia are the earliest signs of alkalosis, and this leads us to do a serum carbon dioxide combining power and a serum chloride determination. The elevation of carbon dioxide is usually associated with a lowered chloride, and if severe, with a rise in blood urea nitrogen, indicative of prerenal azotemia.

Belladonna and other antispasmodics have not been shown to have a regular pharmacologic action on the human stomach in the doses customarily used. I sometimes use tincture of belladonna in small doses as a placebo, because the patient may already be convinced of its value. A mild sedative is occasionally of value, but is a poor substitute for real psychotherapy.

DR. FORKNER: ***Length and results of medical treatment***

I don't think bed rest helps the active ulcer patient very much except when there is bleeding. The hospital may, however, mean more than a bed—it may be a way to isolate him from the problems that worry him, and thus provide an advantage in treatment.

In most cases of uncomplicated acute ulcer in young people, healing will begin with the onset of therapy and will be complete in six or eight weeks. Treatment must be continued for a long period. The chief cause of failure to achieve satisfactory results is the tendency to modify, too early, the strict regimen employed. Even though healing has occurred, recurrences are extremely common — so common, indeed, that peptic ulcer should be regarded as an incurable chronic disease. A safe procedure in cases of duodenal ulcer is to continue a strict regimen, as previously outlined by Dr. Almy, for at least two months after a crater can no longer be visualized, after symptomatic relief has occurred and after the stools have become negative for occult blood. If satisfactory clinical progress has not occurred after three weeks of management, further roentgen studies are required to aid in determining the cause of continuation of symptoms.

Roentgenologists often state that they can find no evidence of an active ulcer or may even go as far as to state that the ulcer is inactive. We, as clinicians, know that one cannot accept such opinions unreservedly. The whole patient must be evaluated. It is a great mistake, often made, to rely solely on any one criterion to judge the activity of a given lesion.

The length of time for healing or whether it will heal at all, is strongly influenced by a number of factors, among them being: 1) The size and depth of the ulcer; 2) The amount of induration in the walls and at the base of the ulcer; 3) The extent to which local blood supply has been interfered with by scars and thrombosis; 4) Completeness with which the factors of pathogenesis have been removed; 5) The persistence of hypersecretion.

Unfortunately, physicians and surgeons often leave patients with the impression that they are discharged as cured when the signs and symptoms have disappeared. A modified regimen should be followed for years. The patient must be told that recurrences are common. His education is of primary importance. Over fifty per cent of patients get recurrences of peptic ulcer within five years. The patient must be familiarized with the factors which are likely to induce recurrences.

Most of the recurrences are due to failure of the patient to maintain a satisfactory regimen and failure of the physician to inform the patient about proper care after the initial treatment for the acute

symptoms. The patient should desist from heavy smoking, avoid concentrated alcoholic drinks, avoid roughage of any sort, avoid highly seasoned foods and, above all, avoid conditions associated with previous recurrences such as nervous tension, anxiety, emotional conflict, and fatigue. Emotional trauma and feelings of insecurity are among the commonest precipitating factors preceding recurrences.

When the patient is unable to live a guarded life, frequent feedings and adequate neutralization of gastric secretions will prevent recurrences in a large percentage of cases and such prophylactic treatment should be carried out for an indefinite period. Usually recurrences respond well to adequate management.

The chance of bringing about quick relief in a given attack of uncomplicated ulcer is about 95 per cent; however, the prognosis for complete and permanent cure is much less even under the most expert care. The incidence of cures diminishes progressively during the first five years after treatment.

Those cases in which it is difficult to achieve excellent results belong, for the most part, to the following groups: 1) Long duration; 2) Severe symptoms; 3) Nervous temperament; 4) Unfavorable environmental situations; 5) Unwilling or incapable of adhering intelligently to the ulcer regimen; 6) Penetrating or perforating ulcers into the pancreas or other surrounding tissues.

In spite of innumerable statistical reports which have appeared in the medical literature, it is difficult to get an estimate of medical cures at the end of any significant period, such as a five-year period.

DR. FORKNER: ***Gastric ulcer and malignant disease***

Search of the literature shows that various authors have found malignant disease in gastric ulcer, in from one to fifteen per cent of cases. The malignant and benign ulcers usually can be differentiated. The malignant transformation of a benign ulcer is, contrary to the older views, extremely uncommon. Ulceration is a feature common to both carcinoma and peptic ulcer. One may mimic the other in symptoms, physical signs, gastric acidity values and x-ray findings. For this reason, the differential diagnosis is of great importance. Some of the more important points in this are as follows:

1. Carcinoma of the stomach, as a rule, occurs in individuals who, during their lifetime, have been singularly free of "indigestion."

2. Every gastric ulcer under treatment should be x-rayed every ten to fourteen days until the niche disappears and if progressive lessening in the size of the crater cannot be demonstrated, then the treatment is inadequate or the lesion is a tumor.

3. Special emphasis must be placed on the complete disappearance of the x-ray defect. Either ulcer or carcinoma may improve; however, a carcinomatous ulcer, as a rule, will not disappear progressively and completely as will be true of a very high percentage of benign peptic ulcers of the stomach. The very occasional chronic benign gastric ulcer, in which it is impossible to secure complete healing, should be resected.

4. The stools of the patient with benign ulcer, under proper treatment will become free of occult blood within ten days. Persistence of occult blood, after three or four weeks, even if x-ray and all other signs are favorable, must arouse a strong suspicion of malignancy and justifies surgical resection.

5. If achlorhydria is found in association with a lesion in the stomach, it must be considered malignant although the presence of normal or hypernormal gastric acidity by no means eliminates the diagnosis of carcinoma.

6. The suspicion of an ulcerating lesion in the distal segment of the stomach with symptoms and signs of rapidly developing obstruction without a defect in the duodenal cap is highly suggestive of malignancy.

In Heuer's 227 cases of ulcerative lesions of the stomach, there was malignancy in 9.6 per cent, but there were only 3 cases, or 1.3 per cent, in which the diagnostic criteria, when reviewed in retrospect, supported fully a benign lesion when a malignant one was present. It seems to me that the important point to bear in mind is this: If there are any features in an ulcer which cast the slightest doubt on its benign character, then operation with radical resection is indicated. Simple excision is not enough.

Those ulcers which follow the diagnostic criteria for benign ulcer and in which there is no suspicion of carcinoma, deserve a trial at medical treatment, provided, of course, that there are no clear cut indications for surgery. Certainly the mere presence of a gastric ulcer is not an indication for surgery. A sound viewpoint is to regard every ulcer of the stomach as a possible malignant lesion until it has been proved to be benign. Fortunately in the vast majority of cases such proof is not difficult to obtain.

DR. FORKNER: ***Gastroscopy***

Gastroscopy is of importance in establishing or confirming a diagnosis of gastric and gastrojejunal ulcer, in differentiating benign from malignant gastric ulcer and in determining the presence or absence of associated gastritis. Occasionally gastritis is of more importance than the ulcer, not only as a cause of symptoms, but also as a source of hemorrhage. Gastroscopy gives much information about the size, the base, the margins and the surrounding mucosa

continued on next page

which helps in the evaluation of activity of a lesion. The value of the procedure is in direct proportion to the knowledge, skill and experience of the observer.

There are certain areas of the stomach which may not be seen with the gastroscope, so called blind spots. This constitutes one of its chief disadvantages. The region of the greater curvature, the posterior wall near the cardiac orifice, areas high up in the fundus adjacent to the esophagus, may be impossible to visualize. Its place is largely in adding to, or confirming a diagnosis rather than in making a diagnosis. If symptoms are strongly suggestive of a lesion in the stomach and yet no defects are found roentgenologically, gastroscopy may be of distinct value. The gastroscope may demonstrate ulcers not seen by x-ray, particularly superficial ones. Failure to see by gastroscopy either benign or malignant lesions in the pyloric area must not be taken as evidence that such lesions are not present. This area is extremely difficult to visualize.

DR. MOORE: *Perforated peptic ulcer*

Although perforation of a peptic ulcer has been reported in the newborn infant by Benbow and even before birth by Walter Estell Lee, of Philadelphia, the usual age group is between 25 and 50 years. In a series studied at Bellevue Hospital, of 101 patients with perforation, the youngest was 18 and the oldest 71 years of age.

In all studies, males far outnumber female patients with perforated peptic ulcer. In the Bellevue series mentioned above, there were 97 males and 4 females. It is interesting that in this series, there were 6 negro patients of which 5 were male and one a female.

In the majority of series reported, perforation is far more common in duodenal than gastric ulcer. In The New York Hospital series reported by Heuer, 74 per cent were duodenal and 20 per cent gastric. At the time of operation, it is often difficult to state the exact location of an ulcer, particularly if there is a great deal of inflammation. Often follow-up x-ray studies give the location differently than that described at the operative table. Duodenal ulcers as a whole outnumber gastric by 4 to 1 and the perforations follow a similar ratio.

Ulcers may perforate without previous symptoms, however, White and Patterson at the Roosevelt Hospital, are correct in stressing the point that careful history-taking will usually elicit chronic symptoms. We found, in 101 patients operated upon in Bellevue Hospital, that 23 had no chronic complaints prior to operation while in the others, there was a history of symptoms from three months to thirty years.

Usually the diagnosis of perforation is quite simple, at times extremely difficult. With a history of ulcer or stomach trouble, there may be several days of increasing difficulty, followed by sudden, sharp, excruciating pain in the abdomen. At times, the pain is so sudden and sharp that it is described as if one had been kicked in the abdomen. There may be pain in the shoulder, usually the right, referred from the diaphragm. Pain then gradually spreads throughout the abdomen. At times, there may be signs of shock and a fall in temperature.

Characteristically, on examination, the abdomen is "board-like" with absence of liver dullness. Tenderness is most marked in the right upper quadrant, but with leakage of gastric contents, it may shift to the right lower quadrant. X-rays may show air under the right diaphragm. Appendicitis remains the condition most frequently confused with perforation. Other conditions to rule out include carcinoma of the stomach with perforation and acute cholecystitis.

Simple closure of the perforation is usually done. These patients are poorly prepared for operation and the least surgery is the best surgery. The perforation is closed by simple suture, usually with reinforcement of the suture line by a small tab of omentum.

In patients operated upon within 6 to 12 hours, some surgeons think the patient is a good operative risk and has only a chemical peritonitis without bacterial involvement. In addition, they think that by simple suture, the outlet of the stomach is obstructed. With this in mind, simple suture is followed by gastro-enterostomy. Although they point to immediate mortality figures which are no higher than the overall statistics following simple suture, they admit that gastro-enterostomy is used only for "good-risk" patients operated upon after perforation. Radical surgery gives better long-term results but the short-term results are not so good. Not all are in condition or come to operation early enough for a radical operation. Even in these, the immediate operative mortality will be higher. At The New York Hospital, we do a simple closure and then, when indicated, additional surgery is carried out.

Ulcers perforate a second time, and as in the case reported by Royster, even five times. This complication occurs following each type operation performed and for each type ulcer. In the series at Bellevue Hospital, there were five second perforations in 101 patients. Estes and Bennett report 11 per cent reperforations. Pearce, at Rochester, New York, in a careful review of this subject, found 33 instances of reperforation in 4,813 cases or 0.69 per cent. It is interesting that mortality in this series, was 27 per cent for the perforations and only 9 per cent in those which perforated a second time. This probably has to do with immunization of the peritoneum to bacteria and also adhesions which have sealed off the ulcer.

We know three things quite definitely concerning the danger of a perforated ulcer developing into a carcinoma: 1) Carcinoma is rare in the duodenum; 2) Most perforated ulcers are in the duodenum; 3) Carcinomas of the stomach do perforate. Now, despite the contention of some that carcinoma develops in gastric ulcer in a high percentage of cases, it is felt by most that the carcinoma started as such and was there from the beginning. Williams, in following patients at the Boston City Hospital, reports only one secondary operation for carcinoma following a perforated ulcer. In the Bellevue series, there was no evidence of cancer. It would appear unusual for a perforated ulcer to become a cancer.

In many instances probably due to bed rest, recognition of the ulcer and institution of proper medical therapy following perforation, the ulcer heals and the patient remains symptom free. In carefully followed patients, about three-fourths continue to have symptoms, one-half have unsatisfactory results, and one-fourth have additional surgery. At The New York Hospital, Heuer found 25 per cent with excellent results, and in those with unsatisfactory results, over half had a second operation.

Patients with perforation should be operated upon immediately. The perforation should be closed by simple suture. When simple suture causes near or complete obstruction, it should be combined with gastro-enterostomy. No drainage of the abdomen should be carried out. Gastric suction and chemotherapy should be used in the postoperative management. Patients with persistent symptoms and/or an active ulcer at the end of six months after perforation while on adequate medical treatment should have an additional operative procedure, preferably gastric resection.

DR. MOORE: *Obstruction due to peptic ulcer*

In obstruction, there is a delay or failure of the stomach to empty. This is evidenced by a failure of meals or alkali to relieve symptoms and vomiting becomes prominent. Obstruction should always be suspected when the patient vomits food eaten 6 to 24 hours previously. A barium meal is by far the best method of demonstrating obstruction and where barium remains in the stomach after six hours, we look upon this as an obstructed stomach. One is able to gain additional information by aspiration of the fasting stomach.

Obstruction is caused by healing of ulcers located at or near the pylorus. As these ulcers heal, scar tissue is formed, and, as all scar tissue contracts, this causes a scar tissue contraction of the opening of the stomach. With this, there is at first associated spasm and edema, both of which increase the obstruction.

It is difficult and, at times, impossible to tell how much of the obstruction is due to scar, pylorospasm or edema. For this reason, these cases are usually treated conservatively for evaluation. First, they are given small frequent feedings in order not to overfill the stomach. Second, alkali is used for treatment of the ulcer. Third, an antispasmodic, as atropine or belladonna, is given to relax the pyloric ring. Fourth, the stomach is emptied by continuous suction or twice daily gastric lavage. Progressive decrease in the 24-hour retention by lavage and barium retention by x-ray indicate a favorable response and that at least part of the obstruction is due to spasm or edema or both. Where dehydration is present and obstruction marked, intravenous fluids are used.

There are numerous preparations of amino acids and protein compounds on the market, all of which are said by the manufacturers to be excellent. They can be given by mouth or intravenously. We have found that while they may prevent further depletion, they usually fail to restore blood protein when it is low. Protein by mouth in the form of eggs, meat and milk is far better. When this cannot be taken, we find blood and plasma by transfusion is far more satisfactory than intravenous amino acids. You are aware of the danger of homologous serum jaundice resulting from pooled human plasma. It is felt this can be prevented by irradiation of the plasma. The important thing to remember is that in a completely obstructed stomach, the patient will go downhill very quickly. They must be gotten into shape and operated upon without delay.

I see no objection to barium by mouth in a patient with complete obstruction, and it gives a tremendous amount of information. It should be used in small amounts where complete obstruction is suspected and then removed by gastric lavage.

In preparing patients with obstruction for operation: 1) Dehydration must be corrected by intravenous fluids; 2) Alkalosis by Na Cl or NH_4 Cl; 3) Blood protein by transfusion and intravenous amino acids; 4) The stomach emptied twice daily or better still by constant suction in order to put this organ at rest. All fluid removed must be measured and replaced; 5) Do not delay in preparing such a patient for operation or waiting for the obstruction to disappear.

Although medical treatment is used to differentiate organic obstruction due to scar from obstruction caused by spasm and edema, it is my impression that the latter groups, although discharged greatly improved, usually return to the hospital because of obstruction and come to operation at a later date.

Most surgeons rely on two procedures, either a gastric resection of which there are several common methods, or a gastro-enterostomy for the treatment of an obstructed stomach. The results of gastro-enterostomy are excellent. An obstructed stomach is the type case best suited for gastro-enterostomy.

continued on next page

In speaking of results, we must think of immediate as well as late. In reviewing the results of gastro-enterostomy at The New York Hospital, Heuer found a mortality of 5.9 per cent and 73.6 per cent satisfactory results as compared to a 7.7 per cent mortality for gastric resection and 83 per cent satisfactory results. You will note that gastric resection gives a higher mortality rate as well as better long term results. With the use of chemotherapy and improved pre- and postoperative care, these mortality rates are now much lower. I am sure if cases of obstruction only had been analyzed, the satisfactory results from gastro-enterostomy would be over 90 per cent.

DR. GLENN: *Bleeding peptic ulcer*

At The New York Hospital, over a period of 16 years, about 2,100 cases were admitted to the surgical service with a diagnosis of peptic ulcer. 380, or 5 per cent of those needing hospitalization, were admitted because of bleeding, or began to bleed while on an ulcer regimen in the hospital.

It is our experience, as well as that of other clinics, that about three-fourths of patients having massive hemorrhage from the gastro-intestinal tract are bleeding from an ulcer. In the year 1947, for example, out of 60 patients admitted for massive hemorrhage from the gastro-intestinal tract, 43 were demonstrated to have an ulcer, two had esophageal varices, one had an esophageal hernia, and four were thought to probably have ulcer, leaving ten on whom a diagnosis was not established even after employing all diagnostic means.

Bleeding peptic ulcer is treated largely by medical means, and, I may add, very effectively. In this particular group of 380 patients, 208 were treated and discharged without operation, 39 were treated by operation while bleeding, and 133 were operated upon after bleeding had ceased. Out of the total series of 380, there were 41 deaths. It is the purpose of the surgeon to reduce this number of deaths, for 24 of these patients died without operation.

Of the 380 patients with massive hemorrhage, there were 39 operated upon while bleeding. Eleven of these died. I believe that several of these eleven would not have died had they been operated upon during an earlier phase of their disease.

The patient who is bleeding from a peptic ulcer should be viewed as a combined medical-surgical patient. He should be followed by both internist and surgeon. If, under complete rest, with such sedation as may commonly be employed, the patient continues to bleed to the extent that he requires 500 cc. of blood per 8 hours, or 1500 cc. per 24 hours, to maintain his blood pressure, then operation should be undertaken. Or, if the patient goes for a period of 36 hours or more, but then bleeds to a low blood pressure and this process repeats itself, he should then be operated upon.

Over the past 15 years, we have gradually gained from our experience the concept that the ulcer which does not respond to conservative measures shortly after they are instituted, may very likely go on to complications and bleeding to fatality.

From 1932 to 1940, we operated on 14 patients during their acute phase of bleeding, out of a total of 161. Of those, five died, a very high mortality rate. We realized then that we were operating too late in the course of the patient's disease, and therefore assumed the policy that they should be operated upon earlier. From 1941 to 1947, we operated upon 25 patients out of 219 with only 6 deaths, a definite improvement.

The proper management of bleeding peptic ulcer is to place the paitent in bed at rest, employ narcotics and sedatives, and a Wangensteen tube in those patients with active bleeding, and observe the amount of blood being lost. I prefer not to feed a patient until bleeding has ceased for at least 48 hours, then start him out on a regular post-operative regimen of water, then albumin water, then milk and cream. In other words, a Sippy regimen. Then, if there is no additional bleeding, x-ray examination may be carried out within a period of about ten days, and the patient placed on a regular medical regimen.

The older age group contains the patients that usually continue to bleed and have recurrent bleeding. Their bleeding may in itself be the immediate cause of death. The difference probably is to be found in the pathology involved. The ulcer in the young is usually superficial. If it involves a vessel, the tissues are soft and retract readily. Whereas, in the older patient, the ulcer is scarred at its base. There is, in addition, sclerosis of the vessel with the result that full retraction is unlikely and control of hemorrhage is dependent upon a clot or plugging of the defect. This is, of course, apt to be dislodged with the return of the blood pressure to normal, or with food material passing over the ulcer.

The operation of choice is subtotal gastric resection. This will remove the bleeding part which is usually along the lesser curvature or on the posterior wall of the duodenum. If this procedure is not feasible, then one may do a partial gastric resection, leaving the pylorus intact, but having in mind to remove the ulcer at a later date. Ligation of the bleeding vessel has been unsuccessful in about half of the attempted instances in our experience.

X-ray may be employed provided you are ready to carry out operation. At the present time we take the patient to the x-ray room with blood running into a vein and have the operating room in readiness. If we are able to locate the ulcer, we immediately undertake operation. If no ulcer can be demonstrated, we do not operate.

In determining the amount of blood lost, careful observation of the patient's pulse, blood pressure

and red count are the simplest aids. Blood volume studies are also of assistance. The general appearance of the patient is of great help. Dehydration must be kept in mind and considered in estimating the red blood count.

DR. GLENN: *Intractible pain from ulcer*

There can be no rule of thumb employed concerning the criteria for surgical intervention in painful ulcer without obstruction or bleeding. The individual patient will determine what should be done. If the pain is incompatible with his ordinary activities, if it prevents him from earning his livelihood, or prohibits him from the common activity of our modern day society, then a definitive procedure that will relieve his pain is justified. There is spectacular relief of pain with vagotomy, but this may not be permanent. Gastroenterostomy will give a satisfactory result in about 80 per cent of the patients, and gastric resection in over 90 per cent.

DR. GLENN: *Vagotomy*

A complete vagotomy as demonstrated by the insulin test, is associated with a low or anacidity. It is held by some that vagotomy blocks the impulses from the cerebrum to the secretory portion of the stomach and as a result, the ulcer heals. Thus one of the factors in ulcer production is removed.

We have observed that within a period of a year or more following vagotomy there can be a return of acidity in the stomach, and we have also observed the return of ulcer symptoms in such patients. The immediate relief of pain associated with primary ulcer or ulcer about an anastomosis has been most spectacular following vagotomy. As the follow-up period for vagotomy increases, there is an increasing proportion of patients with recurring symptoms due to ulcer or its complication.

It remains for the proper status of vagotomy to be determined. At the present time, we are inclined to limit its use to patients with a marginal ulcer. We are emphatic in insisting that vagotomy should not be done for the ordinary duodenal ulcer with bleeding or obstruction, and that it should not be used for treating gastric ulcer because of the possibility of malignancy. There has been relief of pain and healing of the ulcer quite uniformly following vagotomy. But, as I have said, there is a tendency for ulcer symptoms to return and there also can be a disturbance of the motility of the stomach that may have the distressing symptoms of stasis.

DR. FORKNER: *Concluding remarks*

In this discussion, we have tried to place emphasis on some of the chief factors in the treatment of peptic ulcer. We are sure that some of you do not agree with our views. In some cases we disagree among ourselves. There are still many gaps in our knowledge.

1. We are far from a complete and acceptable proof of the etiology of peptic ulcer.

2. Recent experimental evidence on the psychosomatic aspects of ulcer, both with respect to etiology and to therapy, are of special interest and demand further study. It would seem unwarranted to place too much emphasis on this aspect without a longer and more critical appraisal.

3. The treatment of massive hemorrhage from peptic ulcer is of special significance. There are conflicting views. Data are inadequate. Further study and a critical and detailed appraisal of various methods used, is an urgent problem.

4. The whole question of antispasmodics has been raised. Are they useful or aren't they? Who can put this question to the test with evidence that we all must accept? It must be strong evidence if the answer is no, because empirically they have earned an enviable reputation.

5. Is it true that one can not differentiate satisfactorily between a benign and a malignant gastric ulcer? The majority of the evidence says that we can't but I doubt if such evidence will stand a critical case by case analysis. Do we really know the answer to this important question?

6. Is it possible to arrive at a means of inducing a harmless, chronic achlorhydria medically and by this means cure peptic ulcer? This approach demands further careful study.

7. Why is peptic ulcer so predominant in the male sex? Has it anything to do with the hormones —with pituitary functions?

A new idea may bring about a different approach to the problem of peptic ulcer and thereby answer many of the questions asked this afternoon and answer them in a more satisfactory way than we have been able to. There are still many questions to be asked and to be answered.

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CARDIOVASCULAR SYPHILIS*

(*Report from the Cardiovascular Division of the Syphilis Clinic, Rhode Island Hospital Outpatient Department*)

CLIFTON B. LEECH, M.D.

The Author, *Clifton B. Leech, M.D., of Providence, R. I. Associate in Cardiology, Rhode Island Hospital.*

SINCE the establishment of the cardiovascular division of the syphilis clinic in January 1934 in the outpatient department of the Rhode Island Hospital, 1329 syphilitic individuals, divided nearly evenly between the two sexes have been examined. One hundred and nineteen of these were found to have definite evidence of luetic cardiovascular disease. A report of the patients seen in this clinic was made in 1940.[1]

There has been a definite decrease in the number of patients seen in the syphilis clinic in recent years and a corresponding drop in the apparent incidence of luetic cardiovascular disease. This is not entirely due to improved economic circumstances with fewer clinic patients but is due in part to an actual decrease in the effects of late syphilis. In 1948 the total new cases of syphilis reported to the State Department of Health was 900 compared with an average of 1231 reported between the years of 1939 and 1942 inclusive. Although only 99 of the reported cases in 1948 were classed as primary compared with 150 in 1939 there has been such a variation in the figures during the intervening years coincident with the war that no conclusions about the trend in primary syphilis can be drawn. The drop in the number of cases of syphilis is due to several factors, including efficacy of treatment, public education, early detection due to premarital blood tests, tests by the selective service induction centers, and widespread use of antispirochetal drugs; in spite of which it seems likely, on the basis of the reported figures that there are in R. I. at least 10,000 persons who have or have had syphilis.

The present report concerns 60 patients, most of whom are still on the clinic "active list", divided in the following category; uncomplicated *Aortitis* 24, 12 male, 12 female; *Aortic Insufficiency* 28, 23 male, 5 female; *Aortic Aneurysm* 8, 5 male, 3 female; in 2 of the males the aneurysm involved the innominate. The figures for aortic insufficiency emphasize the well-known predilection of this lesion for males.

Age at Detection of Lesion. No patient with *Aortitis* was seen under the age of 40. Fourteen were detected between the ages of 40 and 50, 9 between 50 and 60 and 1 at 62. *Aortic Insufficiency* was detected in 1 male at the age of 31, 5 years after his initial infection, and in 1 male and 1 female at the age of 39. Between the ages of 40 and 50 there were 5, between 50 and 60 there were 11 and over 60 years there were 9. *Aneurysm* of the aorta was found in a female at the age of 38; all others were discovered between the age of 49 and 68.

The Period of Observation has varied widely; the average is approximately 7 years exclusive of those who made 1 or 2 visits only.

Concomitant Central Nervous System Lues was found in 4 of the 18 patients who had spinal fluid examination.

Effect of Treatment. The blood Wasserman reaction after treatment became negative in 4 of the 24 patients with aortitis, in 8 of the 28 with aortic insufficiency and in none of the 8 cases of aneurysm. Recently it has become routine to determine the degree of positivity by Hinton tests in dilution (titre), which may be of value in observing the effect of therapy.

Estimation of the effect of treatment on the basis of the total clinical evidence is that 14 of the patients with aortitis remained unchanged and 10 were improved symptomatically or otherwise. Of the 28 patients with aortic insufficiency 13 remained unchanged and 12 were classified as doing well, 3 became worse.

One patient with aneurysm improved markedly, coincident with the development of an organized thrombus within the aneurysmal bulge and is still under observation in the clinic after 15 years.

So far as possible the treatment of these patients has been standardized but the schedule could not be rigidly adhered to because of varied conditions encountered in the cardiovascular system and because many patients had previously received treatment of late syphilis. Very few of these patients had adequate, if any, treatment of early syphilis,

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which may account for the high percentage of positive serology in spite of therapy. So far as possible the treatment has been started with a series of intramuscular injections in the form of an aqueous solution of bismuth sodium tartrate 1½% (.15 gram to each cc, the dose is 2cc), or 1½cc of stabisol which contains .195 gram of bismuth subsalicylate. If the patient has done well as judged by improvement of symptoms or at least by lack of obvious progression after 10 to 20 injections, then neoarsphenamine by vein has been instituted in a dosage of .1 gram. If 4 doses of this are well borne the dosage has been stepped up by .05 gram for 4 doses, until the maximum dose of .45 gram is reached. If all has gone well the patient has been given a vacation of 3 months and a decision made whether to begin again with bismuth and follow by an arsenical usually sulpharsphenamine or occasionally by marpharsen. This decision is very seldom effected by the serology but rather by the general condition. In the first few years of our experience in this division we were inclined to maintain a more or less continuous but interrupted cycle of therapy indefinitely because we had been taught that late syphilis required more or less constant therapy especially in the presence of positive serology. In recent years we have practically abandoned that routine and now are content after one or possibly 2 courses of therapy merely to maintain the patient under supervision without necessarily reverting again to specific treatment. More recently penicillin therapy is replacing or supplementing the former regimen.

About one-half of the patients received the full course of treatment; about one-fourth received only small doses of neoarsphenamine because larger doses were not well borne, while the remaining one-fourth received no arsenicals because it did not seem wise to give it to them for one or another reason. Only one true Herxheimer reaction occurred although a number of patients have been made mildly ill and have complained of some degree of lassitude and nausea after arsphenamine. Because of the careful supervision there have been none of the disastrous results which are known to follow larger doses of arsenicals and no evidence of late aggravation of symptoms due to a too rapid healing of luetic lesions followed by distortion, contraction and fibrosis.

The evidence that a patient is not doing well under neoarsphenamine therapy is quite definite and usually consists of aggravation or onset of congestive failure with obvious dyspnea and with complaints of palpitation accompanied by an increase in the heart rate. When care was taken to avoid undesirable reactions practically all patients experienced symptomatic improvement. Generally those who had congestive failure when first seen are those who have received the minimum of the arsphenamines. Very recently this type of patient is being treated with penicillin.

Although the criteria for the diagnosis of aortitis are well-known this diagnosis is so important that it seems wise to quote from an earlier report[1]. "The patients whom we diagnosed as having pure aortitis had (1) x-ray evidence of aortic dilatation, (2) the classical tympanitic, hollow, liquid, so-called tambour accentuation of the aortic second sound, (3) a history or symptoms of circulatory embarrassment. Certain authorities add three criteria to these, namely, progressive cardiac failure, substernal pain and paroxysmal dyspnea, and they say that the presence of three or more of these six signs and symptoms in a syphilitic patient under fifty years of age, free from mitral disease and in the absence of hypertension, is strong evidence for the diagnosis of uncomplicated syphilitic aortitis, and that presence of any two of them renders the diagnosis probable."

Patients with uncomplicated aortitis have done well in general with little or no indication of progression of the luetic process; in these, aortic insufficiency has been a rare development. Although patients with slight aortic insufficiency have appeared to profit greatly by treatment, as judged by the arrest or slow progression of the physical signs, the patients with marked aortic insufficiency have exhibited questionable benefit. Patients in this category often do not stand treatment well and many of them require rations of digitalis because of some degree of left ventricular failure. Penicillin therapy may prove to be of definite value in patients in this category. The effect of antiluetic therapy in patients with aortic aneurysm is difficult to evaluate since the lesion often remains unchanged for long periods even without treatment. In such patients antiluetic therapy must be observed with care because of the danger of a therapeutic paradox wherein the otherwise beneficial effect of arsenicals may weaken the diseased aortic wall. Bismuth therapy has been of unquestionable benefit in some cases and is comparatively safe.

Penicillin Therapy. Seventeen patients were treated with penicillin in oil and beeswax by intramuscular injections of 300,000 units per day for 20 consecutive days (600,000 on Saturday none on Sunday). Of these there were 5 with uncomplicated aortitis, 7 with aortic insufficiency, 1 had aortic insufficiency with aneurysm of the ascending aorta and 1 with aortic insufficiency and probable aneurysm. Three patients with lues and probable nonluetic heart disease received the course of penicillin. Two of the 17 patients had no previous therapy, but the others had already gone through the usual course of therapy or had been given preliminary bismuth or bismuth and potassium iodide. In three of these patients the Wasserman or Hinton

continued on next page

tests became negative after penicillin therapy. All were reviewed 6 months or one year after the therapy and were classified as being unchanged or perhaps somewhat better save 2, 1 aged 61 with aortic insufficiency died of congestive failure one week after the penicillin therapy was completed. This patient had been in and out of failure several times, had had only a few doses of neoarsphenamine the maximum of which was .2 gram because of the development of arsenical dermatitis but did have routine bismuth therapy.

Another, aged 61 whose course of penicillin was completed in the latter part of 1946 died in April 1949 of cerebral hemorrhage at the state infirmary and had been in poor condition after the penicillin therapy. A third is reported although he had only 5 injections of penicillin each of which he complained made him feel badly in an indefinite sort of way. His death was thought to be unrelated to the penicillin therapy and he had at the age of 46 arteriosclerotic heart disease with a question of aortitis.

In connection with the penicillin therapy it is interesting that one author[2] states "whereas small, gradually increasing doses of penicillin have been recommended, as has the institution of treatment with bismuth our data failed to indicate the need of either of these expedients." He also states that it is probably safe to treat patients with late cardiovascular syphilis with average therapeutic doses of penicillin but that final conclusions cannot be drawn until a large number of cases have been carefully followed.

Dr. J. E. Moore[3] of the Johns Hopkins Hospital thinks that the risk of the Jarisch-Herxheimer reaction seems not to be great and states that the reaction occurs in all types of syphilis after all types of therapy and consists of a systemic reaction with chills, fever and malaise as well as the focal reaction consisting of increased flare in the local lesions with edema and cellular infiltration. He thinks the evidence is not yet clear as to the value of penicillin in cardiovascular syphilis but that it should be used until we find out.

Our present opinion is that penicillin therapy for late syphilis need not be preceded by other preparatory medication. Our routine, for this form of therapy, recently established, is to administer 600,000 units of penicillin intramuscularly daily for 20 consecutive days.

The value of a separate division for cardiovascular disease in a syphilis clinic has been summarized on the basis of our experience[4] as follows. "Advantages to the profession in the segregation of patients with cardiovascular disease. 1. It allows the physician in the parent clinic to apply vigorous routine treatment to large numbers of patients without fear of aggravating pre-existing syphilitic aortic disease. 2. It relieves the physician in a busy clinic of the burden of careful and repeated examinations of potential or actual cases of cardiovascular lues. 3. It allows the physician who is interested in the subject to study and treat the available cases of cardiovascular disease without unnecessary loss of time. 4. It affords a convenient and practical method of collecting material and patients for teaching purposes. 5. It offers ready opportunities to apply standardized or novel methods of treatment, to study the advantages of one scheme as opposed to another, and to collect whatever data may be involved in special or routine observations.

Advantages to the patient in subclinics for luetic cardiovascular disease. 1. Early aortitis is more apt to be discovered or suspected and the patient protected from potentially dangerous routine treatment. 2. Vigorous treatment, when indicated, is carried out under especially alert and experienced observation. 3. Continuity of supervision in the small subclinic is more easily obtained, to the advantage of the patient. 4. The patient receives the benefit of special consideration of his cardiovascular state, apart from the luetic aspect. 5. The morale of the patient in the subclinic is considerably heightened by the fact of his specialized consideration."

References

[1] Luetic Heart Disease In Rhode Island. C. B. Leech, R. I. Med. Journal, Vol. 24: pp. 25-30; Feb. 1941.

[2] Penicillin in C. V. Syphilis. H. A. Tucker—T. W. Farmer, Arch. of Int. Med., Vol. 80, No. 3: p. 322; Sept. 1947.

[3] Cardiovascular Syphilis: Summary of recent information with special reference to treatment with penicillin. J. E. Moore, Am. J. of Syphilis, Vol. 33: p. 43; Jan. 1949.

[4] The Value of Separate Clinics for Cardiovascular Syphilis. C. B. Leech, The Urologic and Cutaneous Review, Vol. XLIX, No. 2: pp. 87-89; 1945.

BROADENER

I have noticed that members of our local medical society fall into two groups. In one we find those who find little time for activities outside their profession, devoting all their time and energy to earning a living. In the other group are those who, by circumstances or by some driving force, find themselves drawn into outside projects. Much of their talents are given to civic and community affairs—churches, lodges, luncheon clubs, etc.

The physicians of group 2 are in no way superior to those of group 1. They are only living a fuller life, learning more about the problems of people in other walks of life, and familiarizing friends with the problems *we* face. I believe the more of us who fall into this second category, the stronger our profession will be.

. . . Denton Kerr, M.D., Houston, Texas, as reported in *Medical Economics*

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SODIUM FLUORIDE IN DENTAL DECAY

(Guest Editorial by NICHOLAS G. MIGLIACCIO, D.M.D.)

"TOOTH DECAY probably is the most prevalent disease in the United States today." An estimation of 112 million new cavities occurring each year among young Americans above the age of 6 was made by Dr. Hillenbrand, the American Dental Association's secretary.

The use of fluoride in the prevention of dental caries has received a great deal of publicity. A considerable amount of research has been reported in the dental literature and several facts regarding the value of fluorine has been established. The evidence presented by Dr. Dean and Dr. Armstrong indicates that, where there is an increase fluorine-content in the water supply, there is greater resistance to dental decay. It also shows that, where there is an added resistance to dental decay, there is an increased content of fluorine in the teeth, especially in the enamel.

In those areas of the country where the fluorine content of the water is quite high, stained mottled appearance in the teeth was prevalent but a greater immunity to decay was found. The D.M.F. (Decayed-Missing-Filled) rate is about 60% lower in children 12 to 14 years of age than it is in the same group in communities having no fluorine in the water supply.

It has been established that persons who drank water containing natural fluoride during the first ten years of their life have fewer decayed teeth. This was not the case among those who had moved into these areas in later life.

After exhaustive tests on naturally fluorinated water in the various parts of the country, it was determined that the desired amount was about one part of fluorine to a million parts of water.

At present there is no direct evidence that the addition of fluorine to community water supply will decrease the incidence of dental caries in the community. However in eight cities in the United States and Canada fluorine is being added to the domestic water supply. The first community to add fluorine was Grand Rapids in January 1945. Results of these studies cannot be assessed definitely for several more years. This is because the children in these communities must continue to drink the treated water all during the time their teeth are calcifying before the effects can be observed properly.

The observations reported on the effects of fluorine in the drinking water led to experimental work on the effectiveness of fluorides applied to the surface of the teeth. For topical application, Knutson used 2% solution of sodium fluoride in a series of four treatments at intervals of one week, the initial treatment preceded by a scaling and prophylaxis. This method has been effective for children and to be effective it should follow the tooth eruption pattern. The topical application should be given at the ages of 3, 7, 10, and 13 years; and also

continued on next page

giving some consideration to the tooth eruption patterns of the individual child. This method of topical application has won unqualified approval of both the American Dental Association and the United States Public Health Service.

Studies thus far have shown that children who receive these treatments average almost 40 per cent less tooth decay than children who do not receive the treatments. This percentage remained constant in all the different sorts of tests conducted to determine the effectiveness of the method.

The results obtained may differ quantitatively in the individual patient from those which have been observed in controlled clinical investigation since the conditions of treatment are not the same. A great deal more research must be completed before the fluorides can be accepted as a practical or dependable method of caries control.

The use of fluorides in various other forms such as in chewing gum, in mouthwashes, and in dentifrices, and combined with vitamins and minerals in tablet form, have not yet been shown to be effective.

The exact mechanism by which fluorine, either in drinking water or applied topically, protects the teeth is not clearly understood. It seems to exert a two-fold action; 1) Inhibition of acid-forming bacteria and 2) acting on the enamel of the tooth so that it will not dissolve so readily.

It should be re-emphasized that the work on caries-control by means of topical applications of fluoride is still in the most preliminary stage, and deserves much further investigation.

At Bethesda, Maryland, where the National Institute of Health is located, a new National Institute of Dental Research has just begun operations. This new institute was created by Congress a few months ago. It is being operated by the United States Public Health Service. For the first time, it is providing a focal point for all types of dental research.

In conclusion, the future of dental health for our people is bright, brighter than ever before. The public is being awakened to the importance of curbing dental caries, and is beginning to follow the following simple rules:

1) Early and frequent examination of the mouth by a dentist.
2) Early fluoride treatments and treatments of small cavities.
3) A proper diet with refined sugars held at a minimum.
4) Proper brushing of the teeth after eating.

$50,000 In Exhibits
at the ANNUAL MEETING

NOW IS THE TIME . . .

In this issue of the Journal there appears on page 198 the changes in the by-laws of the American Medical Association relative to membership in that organization. Every Fellow of the Society should read this report carefully, as it will answer many questions that might be asked about the assessment of dues this year.

This month, in accordance with the instructions of the Council, the Treasurer of the Society will send out, for the AMA, notice of the $25 dues that must be paid by physicians who will continue their membership. Previously AMA membership was automatically granted to all physicians when they became members in good standing of their State medical society. Now membership carries with it the obligation to support the national association financially.

The work that the American Medical Association does for every physician, and for the public as well, is known to all of us. It requires no elaboration here. The assessment of annual dues is neither strange or unusual. Rather are we surprised that such a large organization could carry on the work it does without direct financial support from all its individual members.

Now is the time for all physicians to come to the aid of their medical organizations.

JOHN FRANCIS KENNEY, M. D.

The medical profession of Rhode Island have lost a friend and helper. John F. Kenney was in all ways a remarkable character. His energies seemed inexhaustible. Yet if he ever did aggravate others by his drive it has not been noticeable to us. His achievements have been multifarious.

We know little in detail of his life at Wareham but it is safe to say he was the live wire of the village. From the time he took his interneship at the Rhode Island Hospital here through his many years of the association with the Memorial Hospital in Pawtucket, his activities had never ceased. Even a severe illness a few years ago, which caused him to give up his practice, did not put him on the shelf.

Starting his career as a Pathologist, he graduated from this, as so many good men have done, into Internal Medicine. He kept up his interest in both these branches and was Chief in the Medical Service at the Memorial Hospital for years; he continued to be their director of Laboratories and he organized and directed their Tumor Clinic. Besides that he had been a Medical Consultant at most of the hospitals in the State, and he was a member of many medical societies. He became President of the State Society in May 1945, and to the day of his death he was a member of the Council and exceedingly active in all its duties; in fact, he was on the telephone working for the State Society on the day

of his death and had already arranged for an important committee meeting at his house four days later.

One of the most striking actions of his life was the development of the Annual All-day Meeting at the Memorial Hospital. His associates there honored him recently by naming this the John F. Kenney Annual Clinic of the Memorial Hospital Internes' Alumni Association. He was personally responsible in getting some remarkably fine groups of visiting doctors to conduct these clinics.

It has been the privilege of few to get more out of life than John Kenney did. He took his work seriously but he took it with evident enjoyment. He was an extrovert. He loved to discuss problems or any of the other aspects of his life. He liked to open his home for such things as committee meetings. A visit there made evident his thoughtfulness concerning the pleasure of his family and his guests.

The Rhode Island Medical Society has been greatly fortunate in having the enthusiastic services of such a man for so many years. He is going to be missed.

DOCTOR'S ORDERS

Rhode Island has no medical school. Nor has the state won any publicity as a national medical center. But the sound and excellent medical knowledge of the physicians of Rhode Island is playing a major role today in public health education in this country and in Canada.

From Presque Isle in Maine to Fort Lauderdale in Florida, from Mobile, Alabama to Santa Barbara in California, from Salem, Massachusetts to Brownsville, Texas, and from New Orleans in Louisiana to Great Falls in Montana the medical advice of our doctors has flowed over radio networks to countless thousands of listeners to the radio program "DOCTOR'S ORDERS."

Laboratory tested and proved sound and successful years ago as the radio program co-sponsored by the Rhode Island Medical Society, DOCTOR'S ORDERS has become a popular education program on both American and Canadian networks. New voices have been called upon to prepare the radio disks, but the basic material written here in consultation with Rhode Island physicians, who participated actively in the original presentations, survives.

New honors came to the program recently, and particularly to the medical profession of Rhode Island, when the Canadian Health Ministry approved of the broadcasting of DOCTOR'S ORDERS in the Dominion provided not a word was changed from the scripts as originally approved by our physicians. Thus, tonight, perhaps, the people of Medicine Hat, of Moose Jaw, of Victoria, Ottawa, Montreal and Fredericton, to mention but a few localities, are heeding the word of medical advice given by physicians of Rhode Island.



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PROGRAM . . . 139th ANNUAL MEETING

RHODE ISLAND MEDICAL SOCIETY

May 10-11, 1950 *At the Rhode Island Medical Society Library, Providence*

WEDNESDAY, MAY 10

2:00 P.M. CALL TO ORDER

WELCOME BY PRESIDENT, PETER PINEO CHASE, M.D.
RECOGNITION OF DELEGATES FROM OTHER SOCIETIES

2:15 P.M. "SURGICAL OPERATION AS AN EVENT IN THE NATURAL HISTORY OF ULCER DISEASE"

FRANCIS D. MOORE, M.D., of Boston, Massachusetts

(Moseley Professor of Surgery, Harvard Medical School and Surgeon-in-Chief, Peter Bent Brigham Hospital)

2:45 P.M. "THE ROLE OF ROENTGENOLOGY IN THE MANAGEMENT OF DUODENAL ULCER"

JOHN T. FARRELL, M.D., of Philadelphia, Pennsylvania

(Professor of Clinical Radiology, Graduate School of Medicine, University of Pennsylvania)

3:15 P.M. "INDICATIONS FOR TREATMENT IN GRAVES' DISEASE"

JAMES HOWARD MEANS, M.D., of Boston, Massachusetts

(Jackson Professor, Clinical Medicine, Harvard University, Chief Medical Services, Massachusetts General Hospital.)

3:45 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

4:15 P.M. THE CHARLES V. CHAPIN ORATION
"BODY FLUIDS AND THE RATIONALE OF FLUID THERAPY"

JAMES L. GAMBLE, M.D., of Boston, Massachusetts

(Professor of Pediatrics, Harvard Medical School and Graduate School; Editor-in-Chief, JOURNAL OF CLINICAL INVESTIGATION 1941-1947; President, American Pediatric Society, 1944; Recipient Borden Award for 1946.)

5:15 P.M. TOUR OF THE TECHNICAL EXHIBITS

continued on page 194



Demonstrotion[1] of effectiveness of Alidase in promoting absorption of fluid subcutaneously. Hypodermoclyses with saline were started bilaterally and simultaneously, the solution for the *left* thigh contoined Alidose.



Ten minutes later the obsorption of 250 cc. of fluid was complete in the left thigh, that in the right required 150 minutes. Note obsence of swelling on the left, its presence on the right.

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1. Schwartzman, J.: Scientific exhibit at the Americon Academy of Pediatrics, San Francisco, Nov. 14-17, 1949.
2. Hechter, O.; Dopkeen, S. K., and Yudell, M. H.: The Clinical Use of Hyaluronidase in Hypodermoclysis, J. Pediat. 30:645 (June) 1947.

*Trademark of G. D. Searle & Co., Chicago 80, Illinois

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

6:00-7:00 P.M. RECEPTION . . . . . At the Narragansett Hotel
(For members of the Society and their guests)

7:00 P.M. DINNER . . . . . At the Narragansett Hotel
(For members of the Society and their guests)

9:00 P.M. *Presiding*: WILLIAM P. BUFFUM, M.D., of Providence
Anniversary Chairman

Presentation of the Charles V. Chapin Memorial Award By—
HONORABLE DENNIS J. ROBERTS
Mayor of the City of Providence

Greetings: HONORABLE JOHN O. PASTORE, *Governor of Rhode Island*

Address: "THE MONTHS AHEAD"
R. B. ROBINS, M.D., of Camden, Arkansas

(Speaker, American Academy of General Practice. Professor of Medical Economics at the University of Arkansas School of Medicine.)

THURSDAY, MAY 11

At the Rhode Island Medical Society Library

Presiding: EDGAR S. POTTER, M.D., *Vice President*

11:00 A.M. "INDUSTRIAL MEDICINE AND THE PRIVATE PRACTITIONER"

JOHN J. POUTAS, M.D., of New York

(Medical Director of Lever Brothers Company)

11:30 A.M. "PERFORATED PEPTIC ULCER; 530 CASES IN RETROSPECT"

ANTHONY CORVESE, M.D., of Providence, Rhode Island*
WILLIAM P. CORVESE, M.D., of Providence, Rhode Island

*(Surgeon Associate Staff, R. I. Hospital; Consultant Surgeon South County Hospital, Wakefield; Consultant on the Gynecology Staff, Charles V. Chapin Hospital)

12:00 M. "WHAT'S NEW AT THE AMERICAN MEDICAL ASSOCIATION"

THOMAS A. HENRICKS

(Secretary, Council on Medical Service, American Medical Association)

12:30 P.M. BUSINESS MEETING OF THE SOCIETY
INSTALLATION OF OFFICERS FOR 1950-51

1:00 P.M. LUNCHEON (A buffet lunch will be served to members of the Society in the basement dining room.)

2:00 P.M. *Presiding*: CHARLES J. ASHWORTH, M.D., *President-Elect*

"DIVERTICULITIS AND CANCER OF THE COLON"

JOHN J. MORTON, M.D., of Rochester, New York

(Professor of Surgery, University of Rochester School of Medicine and Dentistry)

2:30 P.M. "RECENT ADVANCES IN THE TREATMENT OF BRONCHIAL ASTHMA AND PULMONARY EMPHYSEMA"

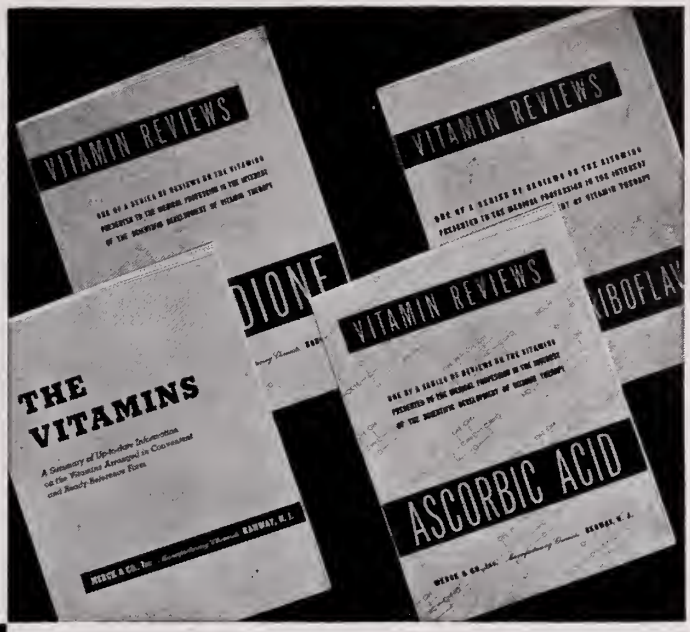
ALVAN L. BARACH, M.D., of New York

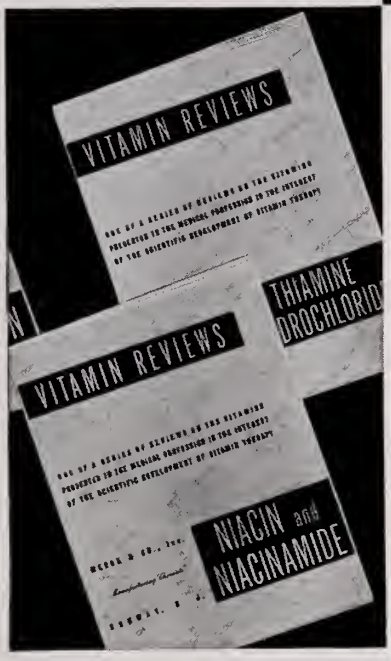
(Associate Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University; Associate Attending Physician, Presbyterian Hospital.)

continued on page 196

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Partial Index of Contents

- **Factors that produce avitaminosis.**
- **Signs and symptoms of deficiency.**
- **Daily requirements and dosages.**
- **Distribution in foods.**
- **Methods of administration.**
- **Clinical use in specific conditions.**

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3:00 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

3:30 P.M. PRESIDENTIAL ADDRESS: "ELABORATION IN MEDICINE"

PETER PINEO CHASE, M.D.

(President, Rhode Island Medical Society; Editor-in-Chief, Rhode Island Medical Journal)

4:00 P.M. "THE RESULTS OF THE TREATMENT OF HYPERTENSIVE VASCULAR DISEASE BY SODIUM RESTRICTION"

MICHAEL DIMAIO, M.D., of Providence, Rhode Island

(Assistant Physician in the Out Patient Department, Department of Medicine, R. I. Hospital)

ALLIED MEETINGS

Woman's Auxiliary to The R. I. Medical Society

Wednesday, May 10 — *Agawam Hunt Club, Rumford*

12:15 P.M. LUNCHEON

1:30 P.M. ADDRESS:

"THE WOMAN'S AUXILIARY IN COMMUNITY LEADERSHIP"

THOMAS A. HENDRICKS

(Secretary, Council on Medical Service of the American Medical Association)

2:15 P.M. BUSINESS MEETING

THE RHODE ISLAND ASSOCIATION OF MEDICAL RECORD LIBRARIANS

At the R. I. Medical Society Library

Presiding: MISS MARY NUNEZ, *President*

10:00 A.M. BUSINESS MEETING

10:30 A.M. "MEDICINE'S CONCERN ABOUT LICENSURE OF MEDICAL RECORD LIBRARIANS"

CHARLES L. FARRELL, M.D., of Pawtucket, Rhode Island

(Chairman, Committee on Public Policy and Relations, R. I. Medical Society; Delegate, American Medical Association)

11:30 A.M. "THE ROLE OF THE MEDICAL RECORD LIBRARIAN IN THE CIVILIAN HOSPITAL VERSUS VETERANS ADMINISTRATION HOSPITAL"

MISS BERNICE LALLY, R.R.L., of West Roxbury, Massachusetts

(Medical Record Librarian, Veterans Administration Hospital, West Roxbury, Massachusetts)



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A M A BY-LAW CHANGES RELATIVE TO MEMBERSHIP

THE House of Delegates of the American Medical Association at its meeting in Washington, D. C., December 6 to 8, 1949, adopted amendments to the By-Laws of the American Medical Association whereby Division One, Chapter II, Tenure of Membership, has been changed to read as follows:

CHAPTER II — *Tenure and Obligations of Membership; Dues*

Section 1.—When the Secretary is officially informed that a member is not in good standing in his component society he shall remove the name of said member from the membership roll. A member shall hold his membership through the constituent association in the jurisdiction of which he practices. Should he remove his practice to another jurisdiction, he shall apply for membership through the constituent association in the jurisdiction to which he has moved his practice. Unless he has transferred his membership within six months after such change of practice, the Secretary shall remove his name from the roster of members.

Sec. 2.—Annual dues, not to exceed $25.00, may be prescribed for the ensuing calendar year in an amount recommended by the Board of Trustees and approved by the House of Delegates. Each active member shall pay said annual dues to his constituent association for transmittal to the Secretary of the American Medical Association.

An active member who is delinquent in the payment of such dues for one year shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address.

Any former member who has forfeited his membership because of being delinquent in payment of dues may be reinstated on payment of his indebtedness.

You will note that the following important changes have been made:

(A) The word "Dues" has been added to the title of Chapter II.

(B) Chapter II has been divided into two sections.

(C) The first sentence of Chapter II, which read, "Membership in this Association shall continue as long as a physician is a member of a component society of the constituent association through which he holds membership," has been deleted.

(D) The words "of the American Medical Association" have been added after the word "Secretary" where clarification is necessary.

(E) The sentence, "An active member shall pay dues or assessments as may be prescribed by the Constitution or By-Laws," has been deleted.

(F) The words "in the American Medical Association" have been added after the words "shall forfeit his active membership" in the second paragraph of Section 2.

(G) The sentence forming the third paragraph of Section 2, with regard to reinstatement, is a new addition to Chapter II.

(H) A new paragraph, forming the first paragraph of Section 2, providing for annual dues not to exceed $25.00 has been added to Chapter II.

The House of Delegates, on recommendation of the Board of Trustees, set the Membership Dues for the Year 1950 at $25.00.

The full effect of the new provisions will have to be studied and developed during the next year. However, the following interpretations of the amended By-Laws are offered for your guidance at this time:

(a) Active membership in the American Medical Association will continue to be limited to those members of constituent associations who (1) hold the degree of Doctor of Medicine or Bachelor of Medicine, and (2) are entitled to exercise the rights of active membership in their constituent associations as provided in Article 5 of the Constitution of the American Medical Association.

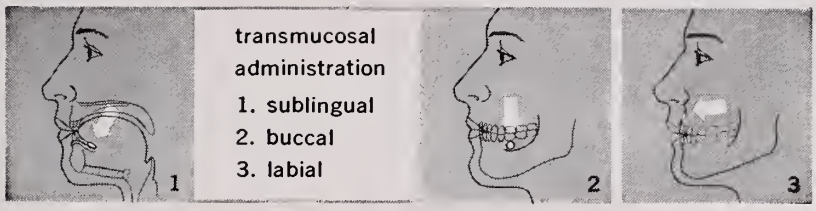
(b) A member of the American Medical Association shall lose his membership in the Association when the Secretary of the American Medical Association is officially informed that a member

continued on page 200

new trend

in hormone

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therapy

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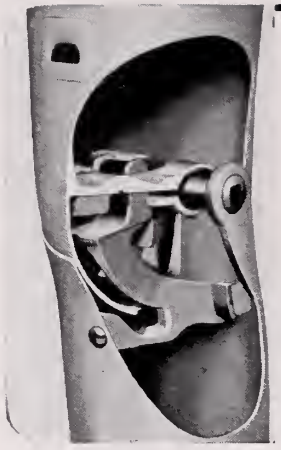
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AMA BY-LAW CHANGES

concluded from page 198

is not in good standing in his component society *or is delinquent in the payment of the American Medical Association dues established by the above change in the By-Laws.*

(c) Forfeiture of membership in the American Medical Association due to failure to pay dues will have no effect on membership in the component or constituent medical societies unless the component or constituent societies amend their respective constitutions and by-laws. It is, therefore, possible that a physician may be a member of his component and constituent societies and at the same time not be a member of the American Medical Association.

(d) The amended By-Laws provide for the collection of the American Medical Association membership dues by the constituent associations for transmittal to the Secretary of the American Medical Association. The detailed method to be adopted by each constituent association will vary in each state. In general, the method utilized by each state for the collection of its own component and constituent association dues should be followed.

Some of the problems involved in the collection and transmittal of dues will be considered in a later communication to you.

It is planned to provide each member of the American Medical Association a membership card and certificate of membership when his dues are paid.

It will be necessary for the Secretary of the American Medical Association to notify those members who are delinquent in the payment of their dues, and this office will, therefore, require a complete list of all active dues paying members.

No changes have been made in the Constitution and By-Laws of the American Medical Association with respect to Fellowship. Eligibility for Fellowship and annual Fellowship dues of $12.00 remain the same. Under the present By-Laws a Fellow will pay for the year 1950 total membership and Fellowship dues of $37.00.

The following members may be exempted from the payment of the $25.00 American Medical Association membership dues: retired members; members who are physically disabled; interns, and those members for whom the payment of such dues would constitute a financial hardship.

No member should be exempted from the payment of his American Medical Association dues who is not exempted from his component and constituent society dues.

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DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The annual meeting of the Pawtucket Medical Association was held at noon in the Nurses' Auditorium of Memorial Hospital.

Nine members were present.

The meeting was called to order by the President, Dr. John Gordon and on a motion from the floor the reading of the minutes of the last annual meeting was omitted. Similarly with the reading of the names of the active and associate members.

Dr. Earl Mara noted that since the Pawtucket Medical Association was now composed of ninety active members the Association was entitled to one more delegate in the Rhode Island House of Delegates. Dr. Henry Turner was voted this member.

It was moved and passed that the Secretary cast one ballot for the slate of officers submitted by the Nominating Committee. The following officers for the coming year were elected:

President ..... Dr. James P. Healey
Vice-President ..... Dr. Kieran W. Hennessey
Treasurer ..... Dr. Laurence A. Senseman
Secretary ..... Dr. Hrad Zohmian
Councilor ..... Dr. Charles L. Farrell
Alternate Councilor ..... Dr. Joseph Doll
Delegates ..... Dr. Earl J. Mara
Dr. Robert T. Henry, Dr. Henry Hanley, Dr. Edward Trainor.



JAMES P. HEALEY, M.D.
President — 1950
PAWTUCKET MEDICAL ASSOCIATION

The new President, Dr. James P. Healey, made a brief speech of acceptance and his first act was to present the outgoing President, Dr. John Gordon, with a gavel.

Dr. Gordon asked that this gavel be placed in the custody of the Secretary and passed on to each succeeding President.

The meeting adjourned until the same evening at 7:15 P.M. when the annual banquet was held at the Biltmore Hotel in Providence.

The members and guests were greeted at the banquet by the new President, Dr. James P. Healey. Guests included Dr. Peter Pineo Chase, President of the Rhode Island Medical Society, Dr. Theodore N. Panaretos, President of the Pawtucket Dental Society, Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society, and the guest speaker, Dr. J. Walter Wilson, Head of the Biology Department of Brown University, whose topic was "Biologic Implications of Atomic Energy." Dr Jesse P. Eddy III presided as Master of Ceremonies.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held on February 16, 1950, at 6:30 p.m. in the Nurses' Dining Room of Memorial Hospital. This was a dinner meeting and fifteen members attended.

The meeting was called to order by the Vice-President, Dr. James P. Healey.

The slate of officers for the coming year was submitted by the Nominating Committee consisting of Dr. E. H. Trainor, Chairman, Dr. Howard Umstead and Dr. Henry E. Turner.

The meeting then adjourned to the Nurses' Auditorium where Dr. Jacob Greenstein, Chief of Medicine, Memorial Hospital, addressed the group. Dr. Greenstein's paper was "The Role of Anti-Coagulant Therapy in Thrombo-Embolic Disease."

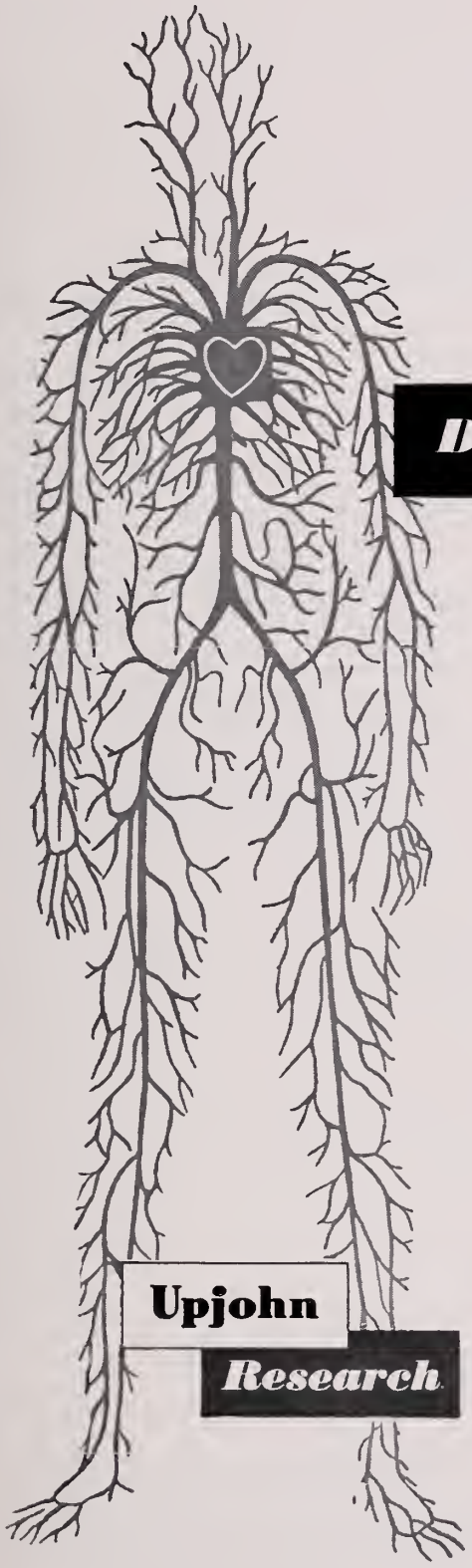
Dr. Jesse P. Eddy discussed the surgical aspects of thrombo-embolism and Dr. Henry Turner spoke at length of anti-coagulant therapy during the post-partum period.

The meeting adjourned at 9:30 p.m.

Respectfully submitted,

KIERAN WILLIAM HENNESSEY, M.D., *Secretary*

continued on page 204



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A price reduction of 26% makes it possible now for more patients to receive the therapeutic advantages of Depo*-Heparin.

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PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, March 6, 1950.

The reading of the minutes of the previous meeting was omitted.

The secretary read announcements of medical-dental seminars to be held on March 21, 28, April 4 and 11, at which members of the Association were invited, and also notice of the Annual Regional Conference of the National Rehabilitation Association, to be held in Providence on April 21.

The secretary reported that at a recent meeting of the Executive Committee the following were among the actions taken:

"It was voted that there shall be a Disaster Committee of the Association, and that each hospital be asked to form a similar committee from its medical staff, and that each hospital nominate a member of its staff to serve on the Association's Committee.

It was voted to lay on the table the question of a committee of the Association on Hospital and Professional Relations as proposed by the Rhode Island Medical Society.

Approval was given the action of Dr. Ralph Richardson, acting for the Red Cross, in sending a list of first aid supplies and a recommendation to industrial and mercantile organizations that they have such supplies available for minor emergencies.

The financial report for 1949 of the Medical Milk Commission of the Association, as audited, was accepted for file."

The executive secretary reported that the Physicians and Surgeons Telephone Exchange in Providence plan to cease its operations, effective April 1. He stated that the Medical Bureau of the Association would endeavor to accommodate all the doctors desiring to transfer to this Bureau as rapidly as possible. He explained that there would be some delay as additional equipment would have to be installed, but he hoped that facilities might be available to meet all demands by the end of the month.

Dr. Troppoli reported that the Executive Committee recommends for election to active membership the following physicians:

John P. Grady of 270 Elmwood Avenue, Providence

Raul Nodarse of 269 Greenville Avenue, Johnston

William F. Maher, of 949 Chalkstone Avenue, Providence

Joseph M. A. Parrillo of 376 Broadway, Providence

Robert F. Rosin of 105 Waterman Street, Providence

A motion was made that these applicants recommended be unanimously elected. The motion was seconded and adopted.

Dr. Dimmitt, presiding in the absence of Dr. Zambarano, introduced as the first speaker of the evening Clifton B. Leech, M.D., Associate in Cardiology, Rhode Island Hospital, who spoke on "CARDIOVASCULAR SYPHILIS."

Dr. Leech found a definite decrease in cases in recent years due to an actual decrease of late syphilis. Whereas, there were 1230 cases yearly in the past, in 1948 only 900 cases were reported. This is due to efficiency of treatment, early detection, and more widespread use of antispirochetal drugs.

Of 60 Patients, 24 had aortitis (none under 40 years of age), 28 had aortic insufficiency, and 8 had aortic aneurism. Blood wasserman reaction was negative in only 12 of 60 patients. Very few of those patients had treatment of early syphilis.

The treatment is standardized,—10 to 20 injections of Bismuth Tartrate followed by neoarsphenamine 0.1 grams to a maximum of 0.45 grams, followed by a vacation of three months. The decision to repeat the course depends more on the physical examination than on the serology. In recent years, after two courses of treatment, they are maintained under supervision. More recently penicillin is used to supplement the treatment or to replace it.

Aggravation of symptoms, e.g. palpitation and signs of failure is evidence they are not doing well. Recently those who had congestive failure are treated with penicillin.

Aortitis is rare. These cases show x-ray evidence of aortic dilatation accentuated and circulatory embarrassment with paroxysmal dyspnea. These have done well on treatment.

continued on page 206

Duffy My Druggist

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THE ORIGINAL ENTERIC COATED TABLET of THEOBROMINE SODIUM ACETATE

Proven Effective IN ANGINA PECTORIS AND CORONARY ARTERY DISEASE

CLINICALLY PROVEN Carefully controlled objective studies in humans and very extensive clinical experience have definitely proven the value of Theobromine Sodium Acetate in treating Angina Pectoris and Coronary Artery Disease.

RECOMMENDED DOSAGE 7½ grains q.i.d. before meals and before retiring. A capsule upon arising if necessary.

SUPPLIED In bottles of — 100 — 500 — 1000

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THESODATE WITH PHENOBARBITAL

*(7½ gr.)	0.5 Gm.	with	(½ gr.)	30 mg.
(7½ gr.)	0.5 Gm.	with	(¼ gr.)	15 mg.
*(3¾ gr.)	0.25 Gm.	with	(¼ gr.)	15 mg.

THESODATE, POTASSIUM IODIDE AND PHENOBARBITAL

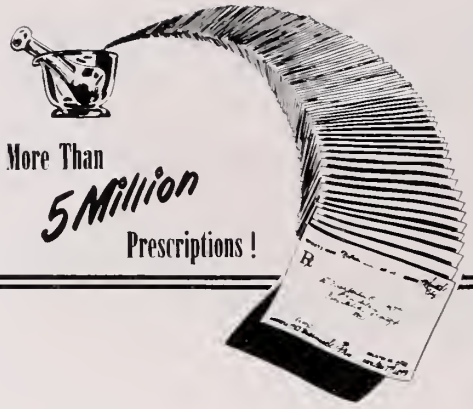
Theobromine Sodium Acetate	(5 gr.)	0.3 Gm.
Potassium Iodide	(2 gr.)	0.12 Gm.
Phenobarbital	(¼ gr.)	15 mg.

Capsules also available in forms marked with asterisk (*) above in bottles of 25 — 100.

Literature with confirming bibliography and physicians' sample sent on request.

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 204

Patients with marked aortic insufficiency do not stand treatment well. However, patients with early aortic insufficiency have done well. Whereas small doses of penicillin are recommended, it is safe to treat these patients with average therapeutic doses of penicillin and this need not be preceded by other treatment. 600,000 units I.M. daily for twenty days is used.

Dr. Leech feels it is of advantage to the man doing cardiology to have these cases under the cardiovascular clinic since in this manner he has a fair sized number of patients to try novel treatment on, and more important still, their cardiovascular state is kept in constant check.

The second speaker of the evening was Marion Ropes, M.D., Associate Physician, Massachusetts General Hospital; Assistant Professor of Medicine, Harvard Medical School, who spoke on "THE PRESENT STATUS OF TREATMENT IN RHEUMATOID ARTHRITIS."

Dr. Ropes stated that rheumatoid arthritis is a generalized disease with infiltration of muscles, nerves, and pericardium with inflammatory cells. Connection tissue in all the body is involved. There is no question that rheumatoid arthritis causes heart disease. Myocardial involvement occurs, also slight valvulitis. Sedimentation rate parallels the subjective and objective findings.

There are three types of this disease.

1. One attack lasting one to three years followed by no more the rest of their lives.
2. Attack after attack months or years apart. In some cases the severity decreases year after year.
3. Severe progressive disease leading to severe crippling. Only 5-10% of cases. This is the most commonly thought of type but actually the least common. Number two is the most common form.

In the treatment, vaccines colloidal sulfur, and snake venom are discarded. Dr. Ropes feels that removal of foci of infection is not entirely proved. We have fairly good evidence now to prove they have little effect on the course of the disease. Very little difference was found in two series of cases. She feels foci should be treated per se and not for the arthritis.

Vitamin D. is a dangerous drug, calcifications by x-ray around joints brought on by large doses. This drug should not be used.

Gold is even more disputed. Evidence against gold is change in attitude of the supporters of gold now that results with cortisone treatment is seen. Prostigmin was used for spasm with no effect.

continued on page 211



NEW!

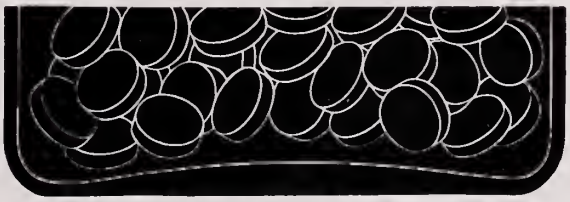
Carmethose-Trasentine

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Controls hyperacidity . . . This combination lowers gastric acidity and forms a protective coating which has been observed in the stomach for as long as three hours.

Controls spasm . . . Carmethose-Trasentine relieves gastric pain also by relaxing smooth muscle spasm. The anesthetic effect of Trasentine further controls gastric irritability. Carmethose-Trasentine is non-constipating, palatable and eliminates acid-rebound.



Issued: Carmethose-Trasentine Tablets: sodium carboxymethylcellulose, 225 mg.; magnesium oxide, 75 mg.; Trasentine, 25 mg. Bottles of 100.
Carmethose without Trasentine is also available for use in cases where the antispasmodic component is considered unnecessary. Available as Tablets, each containing sodium carboxymethylcellulose 225 mg., with magnesium oxide 75 mg., and as Liquid, a 5% solution of carboxymethylcellulose.

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CARMETHOSE T.M. (brand of carboxymethylcellulose)
TRASENTINE ® (brand of adiphenine)

WOMAN'S AUXILIARY TO THE RHODE ISLAND MEDICAL SOCIETY

The spring meeting of the Woman's Auxiliary to the R. I. Medical Society was held on Tuesday, March 14th, at 2 o'clock in the Medical Library Auditorium. The meeting was called to order and the members, new and old, were welcomed by the President, Mrs. William Newton Hughes.

The Secretary's report of the last meeting was approved as read.

The Treasurer, Mrs. Stanley D. Davies, gave her report.

Mrs. Herbert E. Harris, Chairman of the Rummage Sale, was asked to report. The sale, which is held every year to earn money for our Lilian Winsor Harris Nurses' Scholarships, was held November 4th at the Elks Hall. Mrs. Harris thanked everyone who had participated and reported:

Cash received	$407.10
Expenses	42.73
Net profit	$364.37

The President thanked Mrs. Harris and said a vote would be taken at the Annual Meeting to decide which hospitals would receive the scholarships this year.

Mrs. J. Murray Beardsley, Organization Chairman, announced that we had 87 new members: Kent Co. 4; Newport 1; Pawtucket 9; Washington 9; and Providence 64. She said a flower would be presented to all the new members present after the meeting.

Mrs. H. Frederick Stephens, Chairman of the Legislative Committee, gave a summary of the salient features of the year's legislation.

In the absence of the Chairman of the Revisions Committee Mrs. Hughes reported that minor changes to the By-Laws would be presented at the Annual Meeting.

Mrs. William P. Davis, Program Chairman, announced that the Annual Luncheon Meeting would be held at the Agawam Hunt Club on May 10th.

Mrs. Bertram H. Buxton, Hospitality Committee Chairman, invited everyone to stay for tea after the meeting.

Mrs. H. Lorenzo Emidy, Nominating Committee Chairman, reported that the Committee had met and had begun working on its slate of officers for next year.

Mrs. George E. Bowles, Chairman of the Public Relations Committee, reported that she had attended the Medical Society Public Relations Committee Meeting at which the plan of a Speakers Bureau of doctors and doctors' wives had been discussed. A series of four lectures were inaugurated to train the speakers. The women to date, who have attended the classes are: Mrs. Charles Ashworth, Mrs. Arthur Hardy, Mrs. Joseph C. Johnston, Mrs. Arnold Porter, Mrs. Edward V. Famiglietti, Mrs. Frederick A. Webster, Mrs. Charles L. Farrell, Mrs. William Newton Hughes, Mrs. Marton O. Grimes, Mrs. Charles E. Millard, Mrs. Charles F. Gormley, and Mrs. Morris Botvin. Any women who are interested are welcome to attend.

Mrs. Henry J. Hanley reported for the Editorial Committee.

Mrs. Hughes announced that we would probably be entitled to four delegates and four alternates at the National Convention to be held at San Francisco, at the Hotel Fairmont, June 26-30. She requested names of members who planned to attend. Mrs. Robert T. Henry, Mrs. Joseph C. Johnston, and Mrs. Charles L. Farrell said they were expecting to go to the convention.

The President said last year's program of prepared ballots and mimeographed committee reports would be followed at the Annual Meeting in May, and that we would have a speaker from the American Medical Association. It is hoped, too, that Mrs. David B. Allman, President of the Auxiliary to the American Medical Association, would be able to be present.

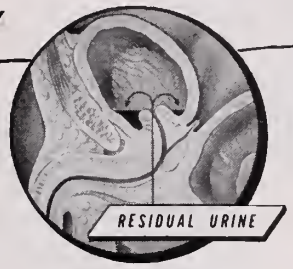
There was no further business and the speaker of the afternoon Dr. Edwin Dunlop, Clinical Director of the Fuller Memorial Sanitarium, was introduced. Dr. Dunlop's subject was "Why I Left English Medical Practice" and he began his talk by saying that since 1884 socialized medicine had been tried by 30 different countries and the experiment in Britain was a lesson for everyone to learn.

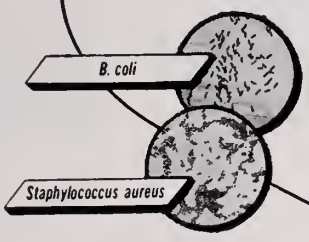
He felt that doctors in England had been psychologically prepared for socialized medicine and had not fought it as they should have.

He pointed out the promise to the people of free choice of doctors and free medicine had disappeared. It simply did not work.

continued on page 211

Anatomical Selectivity





+ *Broad Bacteriostasis . . . . .*



safe RELIEF

URO-PHOSPHATE, excreted in the urine, is naturally concentrated in the pathological area.

URO-PHOSPHATE, while employed most frequently against B. coli infections, also possesses potential utility against a wide variety of both gram-positive and gram-negative organisms, as indicated by basic studies of formaldehyde.

URO-PHOSPHATE is non-cumulative and non-toxic. It provides safe relief from painful symptoms especially in older patients unable to withstand the rigors of other antibacterial therapy.

URO-PHOSPHATE is a balanced combination of 7½ grains of highly purified methenamine and 10 grains of acid sodium phosphate to ensure the acidification necessary for effective release of formaldehyde.

● **DOSAGE**—in acute infections: 2 tablets in ¾ glassful of water 3-4 times daily three hours after meals.

● **SUPPLIED**—in tightly-sealed bottles of 100 tablets.

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The concept that allergic tissue responses are important contributory factors in upper respiratory infections has been widely accepted. To combat these allergic manifestations more effectively, the time-tested, dependable decongestant—Neo-Synephrine hydrochloride— has been combined with a new, highly active antihistaminic—Thenfadil hydrochloride.

Neo-Synephrine® Thenfadil

HIGHLY EFFECTIVE DECONGESTANT ANTIHISTAMINIC

For symptomatic control of the common cold, allergic rhinitis including hay fever, vasomotor rhinitis and sinusitis.



Well Tolerated—No Drowsiness—Neo-Synephrine Thenfadil nasal solution in clinical tests was well tolerated except for a transitory stinging in a few cases. There was essential freedom from central nervous system stimulation: trepidation, restlessness, insomnia; neither was there drowsiness.

Effective—In common colds, allergic rhinitis including hay fever, vasomotor rhinitis, and sinusitis, excellent results were reported in nearly all cases. There was prompt, prolonged decongestion without compensatory vasodilatation. Repeated doses did not reduce the consistent effectiveness.

Dose: 2 or 3 drops up to ½ dropperful three or four times daily. Neo-Synephrine Thenfadil solution contains 0.25 per cent Neo-Synephrine hydrochloride and 0.1 per cent Thenfadil hydrochloride (N, N-dimethyl-N'-(3-thenyl)-N'-(2-pyridyl) ethylenediamine hydrochloride) in an isotonic buffered aqueous vehicle. Supplied in bottles of 30 cc. (1 fl. oz.) with dropper.

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WOMAN'S AUXILIARY

concluded from page 208

He said that because of the unexpected costs of the "scheme" the planned hospitals and health centers had not and would not be built for some time. There are hospital waiting lists now of 200,000 people, while 43,000 beds are empty because there is not enough money for nursing care. The death rate has increased.

He said the doctors are being overworked on trivialities and are hampered by restrictions of equipment and medicine. Progress is now made by diplomacy instead of efficiency.

If the people in this country decide that this is not the kind of state they wish to live in and they insure their health by voluntary plans, Dr. Dunlop thinks the government will be unable to put over its compulsory health plan.

Following this talk, Mrs. Herbert E. Harris, former president, and Mrs. Charles L. Farrell, President-Elect, poured at tea which was served after the meeting.

Respectfully submitted,
MRS. EDWARD V. FAMIGLIETTI, *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

concluded from page 206

Curare helps but the danger is too great. I.V. procaine relieves spasms for a few minutes but is not too successful. X-ray treatment in spondylitis relieves spasms.

Dr. Ropes feels that conservative treatment is best and patients stay in remission stage longer. She treats the patient as a whole, not just the joints. She uses bed rest, emotional rest, support of joints, physiotherapy, heat, and transfusions in anemic patients. Under conservative treatment 50-60% improve. 5-10% go into permanent crippling stage no matter what is used.

Both A.C.T.H. and cortisone alter the manifestations of the disease markedly. In four days symptoms and signs of the disease disappeared entirely. A few scattered patients have not had recurrences but most have had recurrences. Sedimentation rate, plasma portein changes, clinical signs and symptoms all come back, all go down with treatment. All have flared up even with treatment. There is no indication that we have altered adrenal function in these patients. In rheumatoid arthritis there is a shortening of manifestations, but probably not in the chronic manifestations. Psychosis produced by cortisone may last for months. Cortisone may help in finding out the mechanism of the disease, and may lead to something in the way of treatment that is not hormonal.

The meeting adjourned at 10:20 p.m. Collation was served. Attendance was 100.

Respectfully submitted,
DANIEL V. TROPPOLI, M.D., *Secretary*

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BOOK REVIEWS

TEXTBOOK OF SURGERY by 198 American Authorities. Edited by Frederick Christopher. 5th ed. Phil., 1949. $13.00.

The fifth edition of Christopher's "Textbook of Surgery" with its many illustrations and figures and fourteen pages of authors follows the pattern of the previous editions by being a very comprehensive outline of surgery as it is practiced today. The subject matter is treated in a brief, factual and orderly manner which should satisfy the student, general practitioner and most expert surgeon.

The most recent advances in surgical procedure are here presented by the leading men in all branches of surgery.

The textbook is the "Readers' Digest" and "Dictionary" of surgical practice today.

David Freedman, M.D.

ELECTROCARDIOGRAPHY FUNDAMENTALS AND CLINICAL APPLICATION by Louis Wolff. W. B. Saunders Co., Phil., 1950. $4.50.

This latest edition to a large list of text books on electrocardiography apparently arose from the author's lectures on this subject. The primary purpose of this book is to teach the fundamentals of the science and thus to eliminate the need of patterns. In attempting to achieve this end, the book is divided into two parts, the first dealing with the basic principles and the latter with clinical electrocardiography.

The first dealing with the basic principles covers the material necessary in order to gain a working knowledge of the subject. An obvious attempt is made to simplify the material but clarity is not achieved to any greater extent than with several other more complete texts that are available. The illustrations used are adequate but are not profuse in number. The clinical portion of the book concerns itself with bundle branch block, ventricular hypertrophy, myocardial infarction, pericarditis, pulmonary embolus and the Wolff-Parkinson-White syndrome. This entails some repetition of the matter previously described and the bulk of the material is presented as example cases. The method of presentation makes for easy reading and presents most of the necessary material. It makes, however, reference to a specific subject almost impossible. The section on the Wolff-Parkinson-White syndrome is excellent. The main criticism of the book, however, is not in the subject matter covered. As this book is obviously meant for the general practioner and novice, the omission of any reference to arrhythmias with the exception of the Wolff-Parkinson-White syndrome is a serious fault. This combination, with the paucity of specific information concerning the few important abnormalities presented, decreases its value greatly. The lack of a bibliography, as always, in any book designed to interest the reader in acquiring further information is most regrettable.

C. Warren Irvin, Jr., M.D.

PHYSIOLOGY OF HEAT REGULATION AND THE SCIENCE OF CLOTHING. Prepared at the request of the Division of Medical Sciences, National Research Council. Edited by L. H. Newburgh, M.D., Professor of Clinical Investigation, The Medical School, University of Michigan. W. B. Saunders Company, Phil., 1949. $7.50

This book is edited by an M.D. and two of the articles are written by physicians. The other thirteen articles are by men with advanced degrees and holding important positions, such as professorships. It is a carefully written book by a group of experts. It is distinctly not light reading.

There are many charts and scientific formulae that I think the average physician would find a great deal of difficulty in interpreting; however, one interested in these problems would find much meat in it. The first article of seventy pages is by an Anthropologist and is the study of the way in which many of the lesser known people of the world adapt themselves to extremes in climate. Then there are a number of monographs on such subjects as the way heat is transferred, the manner in which the body regulates or adjusts itself to heat, and the manner in which different parts of the body lose their heat and the factors in such things as heat and moisture that influence our feeling of body comfort.

The latter one-third of the book is given up to the study of clothing; how it is constructed and particularly how it aids or interferes with such

things as the transfer of heat, the handling of moisture both from nature and from our bodies. The difficulty with this is that the so-called uncivilized people who really try to adjust their clothing to their needs will not be able to read the book and the rest of us certainly will disdain to consider clothing from a scientific standpoint.

We wish the authors would have adopted the habit, so common in the writing of medical articles nowadays, of ending with a good summary. This is an authoritative book and no doubt will be valuable for reference.

PETER PINEO CHASE, M.D.

PSYCHOSOMATIC MEDICINE. By Edward Weiss and O. Spurgeon English, W. B. Saunders, 2nd. Ed., Philadelphia, 1949. $9.50.

The new and enlarged 2nd edition of this already accepted standard work incorporates several helpful changes, including much experience gained in military medicine during World War Two. Especially worthy of note is the additional material on psychosomatic diagnosis, and on social work as applied to psychosomatic problems. In view of the widespread recognition of the first edition, it goes without saying that this remains the principal and most valuable work for the practitioner interested in this field.

In style the work is still in its clearly-outlined form with captioned paragraphs which make the book convenient for reference and for skimming, but a bit fragmentary for continuous systematic reading. Several important areas are summarized in brief thumbnail outlines which are very helpful. The one on "General Principles of Management of Psychosomatic Disorders" should be under the glass on every physician's desk.

The psychosomatic concept is now a well-accepted and useful one and the work is therefore a most important and practical help to everyone dealing with patients and their problems.

ALEX M. BURGESS, JR., M.D.

FUNDAMENTALS OF OTOLARYNGOLOGY. By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology, Director of Division of Otolaryngology, University of Minnesota Medical School. Pp. 443, with 184 illustrations. Philadelphia & London: W. B. Saunders Co., 1949.

This text book by Dr. Boies and his associates is designed primarily for use in teaching the fundamentals of otolaryngology to the undergraduate medical student and to provide this same fundamental information to the physician who is not a specialist. It is described by the author as representing the opinion of today that has a factual basis, and for this alone the author deserves commenda-

continued on next page

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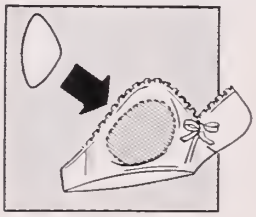
GAspee 8123

NEW STATE COMMITTEE

In accordance with the request of the Providence Medical Association that its Committee on Air Pollution Abatement be replaced by one representing the entire state, Dr. Peter Pineo Chase has announced the appointment of the following committee of the Society to be known as the Air Pollution Abatement Committee:

EDWARD F. BURKE, M.D., *Chairman*
FREDERICK BURNS, M.D.
EDWARD S. CAMERON, M.D.
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tion. The book is extremely well written and has a sufficient number of well chosen illustrations to clarify the procedures and treatments described.

At the end of each chapter are a few well chosen references so that the reader may supplement the text with the recent contributions on the subject.

While this is planned for use as a text book, it should be in the hands of every man in general practice.

E. B. GAMMELL, M.D.

CARDIOVASCULAR DISEASE by Louis H. Sigler. Grune & Stratton, Inc., N. Y., 1949. $10.00

The outstanding feature of this complete and modern work is the simplicity of the language, especially in the sections dealing with physiologic phenomena which are devoid of "jargons not entirely or clearly comprehensible to the clinician." This book emphasizes the fundamentals, differential diagnosis, prognosis and treatment of cardiovascular disease and the text "attempts to cover all problems the physician is called upon to solve in the course of his practice." In this attempt the author's personal experience is frequently cited as the basis of opinions expressed, but divergent views are adequately presented.

Notable features are the drawings and diagrams illustrative of the phenomena produced by valvular diseases.

Although significant advances in the diagnosis and treatment of heart disease have been very numerous in recent years this book appears to have omitted nothing except possibly some of the most theoretical and as yet unaccepted considerations. The chapter on heart failure, for example, presents in a common-sense manner numerous documented explanations of the manifestations of heart failure, omitting the details of interesting but otherwise highly theoretical opinions.

There is no section on electrocardiography as such, which is a laudable departure in a book of this nature since there are so many excellent texts devoted exclusively to the subject.

This book is a worthy addition to the texts on cardiovascular disease and should be of definite value to the internist as well as the general practitioner.

CLIFTON B. LEECH, M.D.

DISEASES OF THE FOOT by Emil D. W. Hauser, M.D. W. B. Saunders Co., Phil., 1950. 2nd ed. $7.00

The first edition of "Diseases of the Foot" published in 1939 was well received by both general practitioners and orthopedic specialists alike. The text has been revised during the past few months

continued on page 216

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BOOKS RECEIVED

The Editor acknowledges the receipt of the following books:

Report of the Medical Research Council for the Years 1945-1948. Lond., 1949. 5s.

R. E. O. Williams & A. A. Miles—*Infection and Sepsis in Industrial Wounds of the Hand.* Medical Research Council, Special Report Series No. 266. Lond., 1949. 1s.6d.

Melchior Palyi—*Compulsory Care and the Welfare State.* National Institute of Professional Services, Inc. Chic., 1950. $2.00

Torsten Sjögren—*Genetic-Statistical and Psychiatric Investigations of a West Swedish Population.* Acta Psychiatrica et Neurologica, Supplementum 52, 1948.

Torsten Sjögren and Tage Larsson—*Microphthalmos and Anophthalmos with or without Coincident Oligophrenia.* Acta Psychiatrica et Neurologica, Supplementum 56, 1949.

BOOK REVIEWS

concluded from page 214

and several changes have been made in it, particularly in reference to circulatory disturbances and infections.

The book is not large having about four hundred pages. The print throughout is a fairly large, bold type which is very easily read. The style is simple and it is possible to comprehend the subject matter without difficulty. Every conceivable phase of foot and leg disorder is included and yet this is not to be considered an encyclopedia. The most successful modes of treatment are briefly outlined. At the end of each chapter there are references for further reading or study. I hesitate to select any section or chapter as being superior to the others, but I feel that the practitioner will find the discussion on static and postural deformities most enlightening.

In the foreword, Dr. Hauser states, "Function is the prime consideration in the treatment of any condition affecting the foot and has been the theme throughout the text." This theme has been followed closely and the stress placed upon it should make it worthwhile reading.

William V. Hindle, M.D.

MITCHELL — NELSON TEXTBOOK OF PEDIATRICS, edited by Waldo E. Nelson, M.D., 5th ed., W. B. Saunders Co., Phil. 1950. $12.50

Doctor Nelson is to be congratulated for the new fifth edition of Mitchell—Nelson Textbook of Pediatrics. While the previous edition of 1946 has been generally considered to be the most complete single reference volume of pediatrics, when compared to the 1950 edition it is difficult to realize that medicine has made such great advances in the past three or four years.

With three hundred more pages, new photographs and charts the text has been completely revised. Some of the highlights are the new rewritten sections on Physical Growth and Development; Parenteral Fluid Therapy, including the role of potassium; Inborn Errors of Metabolism; Mycotic Diseases, including the use of viral diagnostic laboratory; and Adolescence. The section on congenital heart disease makes note of cardiac catheterization and of the advances in surgical treatment.

The text is precise, generously illustrated and the double column arrangement makes for easy reading.

Leonard Bellin, M.D.

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SOCIETY	DELEGATES	COUNCILLOR	OFFICERS	MEETING
Kent County Medical Society	Rocco Abbate Peter Erinakes	Arthur Hardy	*President*, Joseph Kent *Vice Pres.*, Jean M. Maynard *Secretary*, Edmund Hackman *Treasurer*, John Mack	3rd or 4th Tuesday of each month
Newport County Medical Society	Frank Logler Donald B. Fletcher	Samuel Adelson	*President*, Henry W. Brownell *1st Vice Pres.*, Robert L. Bestoso *2nd Vice Pres.*, John M. Malone *Secretary*, Osmond Grimes *Treasurer*, Norbert U. Zielinski	4th Tuesday of every other month, starting September
Pawtucket Medical Association	Earl Mara Edward H. Trainor Henry Hanley Robert T. Henry Henry Turner	Charles L. Farrell	*President*, James P. Healey *Vice Pres.*, Kieran Hennessey *Secretary*, Hrad Zohmian *Treasurer*, Laurence A. Senseman	3rd Thursday of every month
Washington County Medical Society	Louis Morrone Samuel Nathans	John Paul Jones	*President*, Clifford Hathaway *1st Vice Pres.*, Thomas Nestor *2nd Vice Pres.*, Julianna R. Tatum *Secretary*, Samuel S. Farago *Treasurer*, Samuel S. Farago	2nd Wednesday of every 3 months, starting October
Bristol County Medical Association	John A. Mellone	Paul C. Bruno	*President*, Ralph J. Petrucci *Vice Pres.*, Hubert Holdsworth *Secretary*, Arcadie Giura *Treasurer*, Antonio DiAngelo	3rd Tuesday of each month
Woonsocket Medical Society	George Keegan Joseph McKenna	T. J. Lalor	*President*, Leo Dugas *Vice Pres.*, Alfred King *Secretary*, Emil Kaskiw *Treasurer*, Paul Boucher	No fixed date
Providence Medical Association	Robert Baldridge J. Murray Beardsley Peter Pineo Chase E. Victor Conrad Frank B. Cutts William P. Davis Donald DeNyse John Dillon	Albert H. Jackvony	*President*, Ubaldo E. Zambarano *Vice Pres.*, Frank W. Dimmitt *Secretary*, Daniel V. Troppoli *Treasurer*, J. Murray Beardsley	1st Monday of every month; Oct.—May inclusive
		William J. H. Fischer David Freedman Herman Grossman Peter Harrington William Horan Russell Hunt	Louis I. Kramer Herman A. Lawson Edward McLaughlin Robert Murphy John C. Myrick Joseph C. O'Connell	Michael O'Connor Edwin O'Reilly Alfred Potter Louis Sage Daniel Troppoli George Waterman

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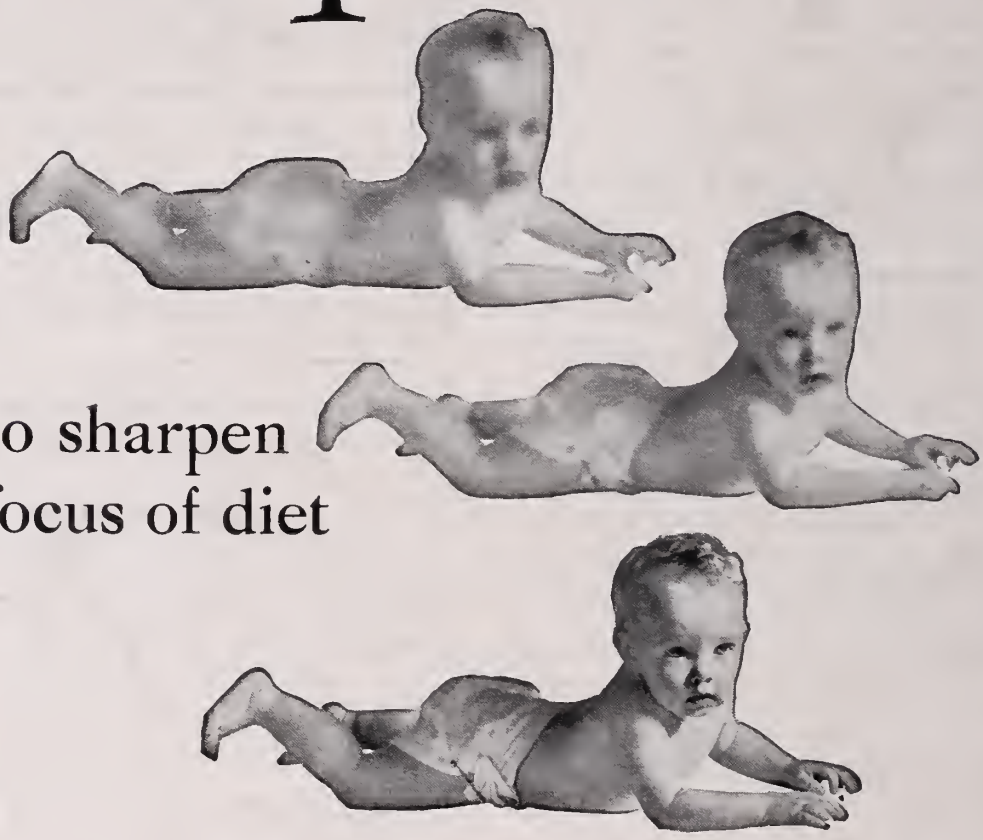
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CONGRESS ON OBSTETRICS AND GYNECOLOGY

The International Congress of Obstetrics and Gynecology, sponsored by the American Committee on Maternal Welfare, will meet May 14—19, at the Statler hotel in New York City.

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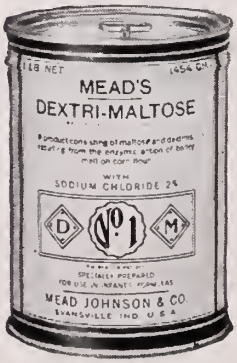


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Hewitt, W.L., and Williams, B., Jr.: New England J. Med. *242*:119, 1950

oxic reactions or signs of intolerance were observed."
Payne, E. H.; Knaudt, J. A., and Palacios, S.: J. Trop. Med. & Hyg. *51*:68, 1948

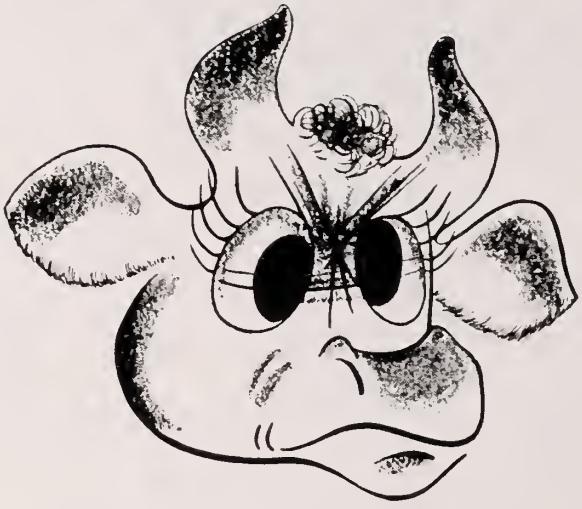
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Ley, H. L., Jr.; Smadel, J. E., and Crocker, T.: Proc. Soc. Exper. Biol. & Med. *68*:9, 1948

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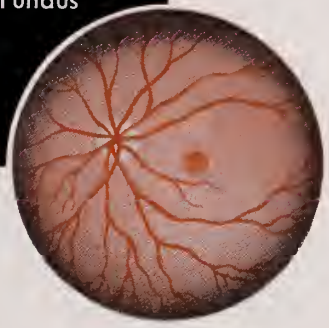
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*Pitt, C.K.: The Art and Science of Artificial Infant Feeding, J.M. Asso. Ala. 19:101 (Oct.) 1949.

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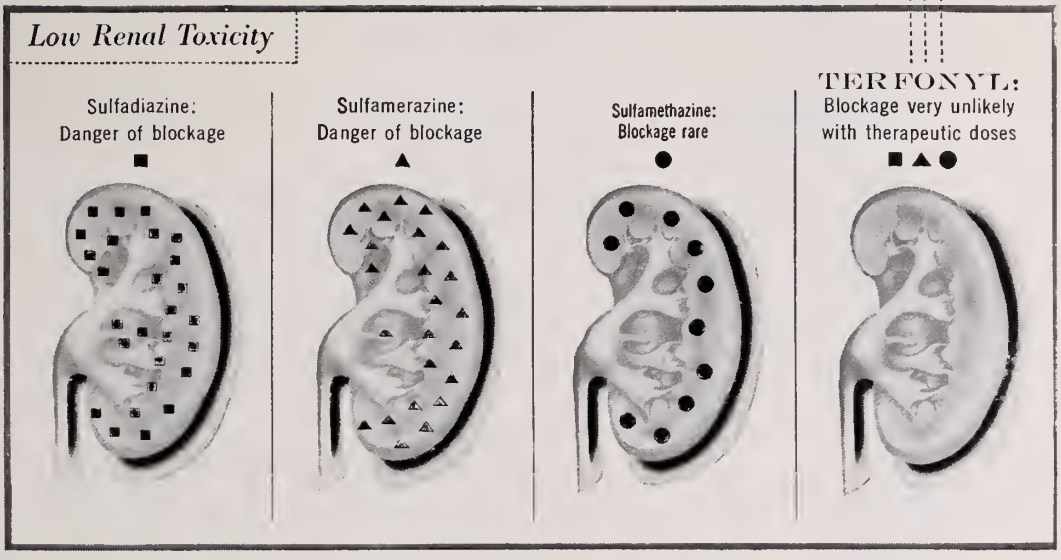
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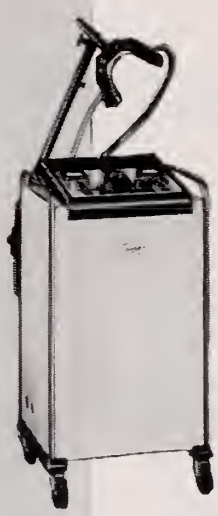
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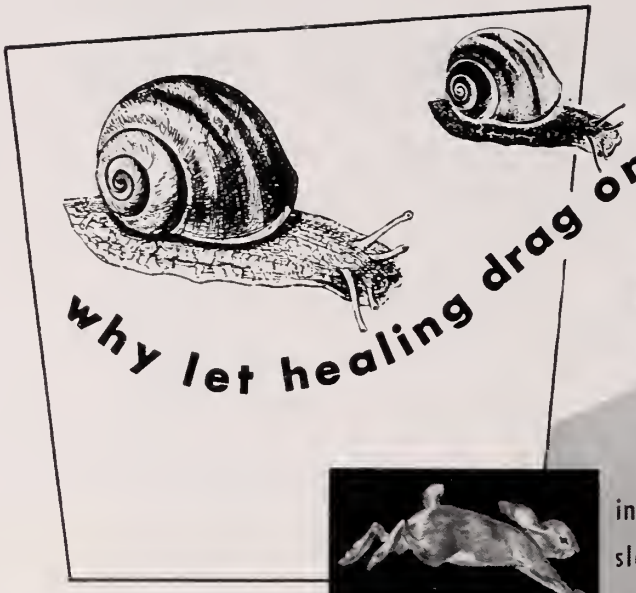
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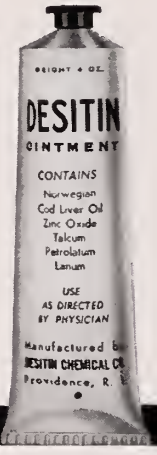
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1. Behrmon, H. T., Combes, F. C., Bobroff, A., and Levilicus, R.: Industrial Med. & Surg. 18:512, 1949.



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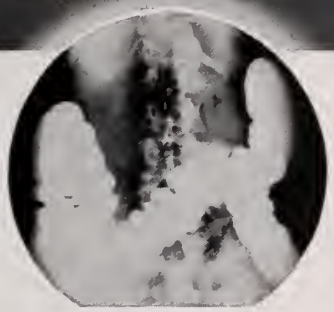
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[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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DIAGNOSIS OF A CASE OF UTERINE MALFORMATION WITH KIDNEY AGENESIS

HAROLD LIBBY, M.D.

The Author. *Harold Libby, M.D., of Providence, Associate Staff Surgeon, Rhode Island Hospital; Consultant Staff, Miriam and Lying In Hospitals.*

THE normal uterus is formed by fusion of the lower segments of the two mullerian ducts. The upper ununited portions of the ducts become the fallopian tubes.

The mullerian duct of each side has a common origin with the kidney of that side. They both arise from the early embryonic tissue,—the mesonephros or wolffian body. This mode of development explains why malformations of the uterus and kidney sometimes occur simultaneously.

Deformities of uterine structure may result from improper or incomplete union of the lower segments of the ducts. The types thus formed are the arcuate, the septate, (partial or complete), the bicornate, and the double uterus, (uterus didelphys). This last named group is caused by the side by side development of the uterine canals instead of by mutual fusion. The term used for this group namely, "double uterus," is often used in a more general sense. It is frequently descriptive of any uterine malformation with two cavities such as the septate or the bicornate type. The two cavities may be more or less separate and each more or less capable of containing the products of conception in event of pregnancy. This type of uterus may have each side equally or unequally developed, and may or may not have a duplication of the cervix and/or the vagina.

The other main reason for uterine malformation is incomplete or deficient growth of the mullerian ducts. As a result there is the condition of absent uterus, the unicornate uterus, and finally the bicornate uterus with a rudimentary horn. This last type, another form of double uterus, results from growth of one duct and only partial or rudimentary growth of the other. The cavity of the accessory horn may or may not communicate with the canal of the more normal horn. It is an important type clinically.

Congenital atresia of the canal of the rudimentary horn of a double uterus may result in hematometra, a serious condition usually requiring a laparotomy for the removal of the rudimentary horn and sometimes the entire uterus.

Novak[1] states that "When the development of one duct is normal and the other very imperfect, varying degrees of rudimentary horn of such a bicornate uterus are produced, and these may assume much gynecological importance, not only because of the diagnostic problems which their presence may entail, but because of the fact that such rudimentary horns may become the seat of pregnancy."

Pregnancy in a rudimentary horn is very similar to ectopic gestation, and according to DeLee-Greenhill[2], rupture of the pregnant uterus is apt to occur about the middle of pregnancy. It is obvious that the deformity itself may become a potentially dangerous condition if pregnancy ensues.

Pregnancy has been known to occur, and proportionately often, in an incompletely developed horn the canal of which had no proven connection with the uterine canal. For these cases pregnancy must have followed external migration of the spermatozoa or of the fertilized ovum[3].

A statement by Graves[4] that "Double formation of the uterus, as a rule, has no special clinical significance unless there is atresia and hematometra" is generally conceded to be correct. One can live quite comfortably with almost any type of uterine malformation if this condition is not present and pregnancy is not an issue. That is why by far the largest number of cases remain undiscovered until some complication arises. Most gynecologists and obstetricians rarely see more than one or two abnormalities of the uterus even after years of practice.

continued on next page

Deformities of the uterus may be accidentally discovered by pelvic examination; by the study of sterility with X-ray and the opaqua media; by a laparotomy for some unrelated abdominal pathology, or for a supposed tubal pregnancy which proves to be a ruptured pregnant rudimentary horn; occasionally too by a caesarean operation needed because of some interference with the normal course of labor. Necropsy has often disclosed these abnormalities, and surprisingly enough in women who have had uneventful and successful pregnancies and labors, without arousing during life the least suspicion of their anomalies.

Case History

On June 1st, 1944, the patient, a well developed girl of fourteen, while in class at school began to menstruate unexpectedly and profusely. Her dress became stained, and she obtained permission to go home. Her mother, alarmed, called her physician who sent her into the Rhode Island Hospital where she was seen by the writer.

Her family history was essentially negative. She had no brothers or sisters. There were no familial diseases.

Previously she had had scarlet fever and whooping-cough. Measles only recently. Pyelitis at the age of five when an i.v. urography was done. The findings were inconclusive.

Her menstrual periods began a year before at thirteen. For the first six months these occurred every two or three months and were scant. For the latter half of this first year periods were approximately every three weeks, with duration of seven days and amount about normal. She seldom had any pain.

The patient had undergone an attack of measles several weeks before entering the hospital, and only about 10 days before entrance had finished a seven day period which was accompanied for the first time by fairly marked lower abdominal pains and occasional dysuria. Because this pain continued, and because the intravenous urography of ten years before gave inconclusive results, another was done on May 26th, six days previously.

This later urography ". . . showed a normal functional response by the right kidney. This kidney was moderately hypertrophied. No function whatever was demonstrated by the left kidney. It is possible that we may be dealing with an absence of the left kidney."

The patient, typically feminine, was calm and co-operative. Heart and lungs were negative. Breasts were well developed. The abdomen was soft except in the lower portion above the symphysis. Here the patient showed moderate tenderness upon pressure. No mass was felt. The liver edge was at the costal margin. Kidneys were not felt. The vaginal discharge was very dark, thick and tarry-like. It had every appearance of retained menstrual blood. The hymen was intact.

Upon rectal examination the cervix and only part of the fundus could be felt. One derived the impression of hardness of the uterus. There was a feeling of fullness on the left side not apparent on the right. The adnexa could not be felt.

The vaginal flow gradually subsided along with the pain which was not severe. After three days there was only a very slight staining.

On account of the last urography report a cystoscopy was done while she was still in the hospital. With the cystoscope in place, and after prolonged search the left ureteral orifice could not be visualized. A No. 5 catheter passed readily to the pelvis of the right kidney. Indigocarmine i.v. appeared in three minutes from the catheter and concentrated very rapidly. There was no evidence of the dye in the bladder, for the left side, after 15 minutes.

At the time of discharge from the hospital the patient was known to possess only a right kidney. She also had had a menstrual episode which suggested atresia somewhere in the genital tract. These two facts pointed to the possibility of a uterine malformation being present. The diagnosis was only a conjecture and had to await further proof.

The patient took up her daily life again as any happy normal girl would. She returned to the office after long intervals but with no complaints. She was not much disturbed by her menstrual periods which came irregularly, sometimes every 30 to 31 days, and again every three or four months.

Less than three years later, early in 1947, the patient's mother came for prenatal care. Her pregnancy was uneventful until her 6th month, when she did not feel fetal life for more than a week. In July 1947 she spontaneously miscarried a 5½ months still-born fetus. These facts are stated because the fetus was congenitally deformed, without hands or feet,—a case of hereditary agenesis of the extremities.

This would seem to strengthen the evidence, in the patient, of a possible congenital uterine anomaly, of the deficiency type.

The patient married in January, 1949, at the age of 19. Her menstrual period, after a lapse of several months, occurred two days before the wedding day, and lasted seven days. She came to the office about a month later, on February 15th. Contraception, at least for the present, was being practiced.

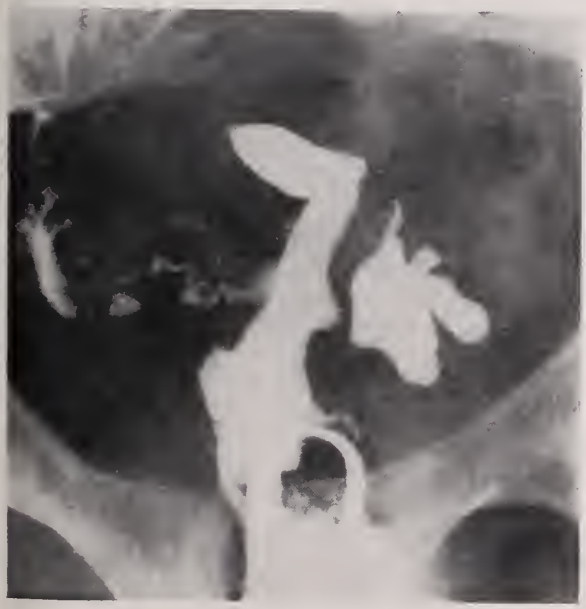
Upon bimanual examination the vagina readily admitted two fingers. There was a single cervix, rather large and without erosion. The fundus, anterior, felt somewhat irregular in shape, slightly large, and partly hard. The adnexa could not be felt. A probing sound was easily passed to the fundus, meeting with no obstruction. The uterine canal seemed somewhat longer than expected for a nulliparous uterus.



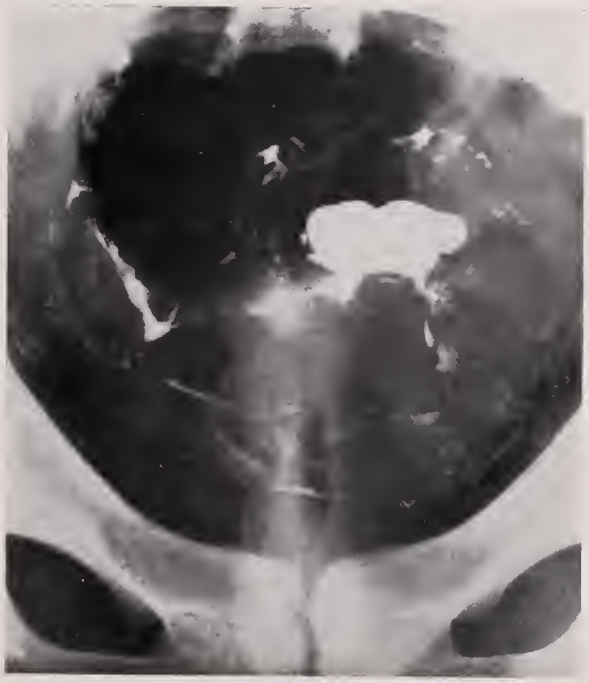
1. Right horn of uterus with patent tube. No left horn seen.



2. Note projection. Small left sac begins to fill.



3. Further filling of rudimentary horn.



4. Appearance next day, (20 hrs. later).

continued on next page

At this time arrangements were made for a hysterosalpingography to be done several days after the cessation of her next period. This was done on April 11th, 1949, six days after her period ended, at the office of the roentgenologist*.

The patient was placed on the X-ray table in lithotomy position. After the usual cleansing of vagina and cervix, and the employment of sterile instruments, the cervical canal was injected with iodochlorol. A self-retaining cannula was used with a Jarcho tenaculum holding the anterior lip of the cervix. A 10 c.c. lok-syringe containing the iodochlorol was attached directly to the cannula. Under fluoroscopic control a number of spot films were made. Several of these are shown.

Injecting slowly, the cervical canal and the uterine cavity were promptly outlined, showing a somewhat widened cornua on the right side. The fallopian tube on this side was promptly entered, and the opaque medium readily spilled over into the peritoneal cavity. No outline of a left cornua was seen. For a brief moment it appeared that the very rare unicornate uterus, (with kidney agenesis), was present, as can be seen from the developed film. (Fig. 1)

But the advantage of fluoroscopic observation showed itself. After a moment or two a projection was noted arising from the left wall of the lower uterine canal.

The writer thereupon shortened the intrauterine length of the cannula above the rubber cone obturator and injected again with the remainder of the 10 c.c. of iodochlorol. A small round sac about ¼ to ½ an inch in diameter then appeared which seemed to connect with the uterine canal, first by a narrow area and then by the broad base of the projection mentioned at the lower left wall of the uterine canal. (Fig. 2)

A progressive further filling of the small pouch resulted eventually in the outline of an irregular sac which measured almost one inch in diameter. This is undoubtedly a rudimentary horn. (Fig. 3)

A film taken after removal of the instruments showed that the uterine canal, as well as the right cornua had emptied to a large extent. The irregular pouch on the left side was still filled more or less completely.

A film taken the next day, twenty hours later, still showed the opaque medium in the irregular sac, the remainder being scattered in the peritoneal cavity. (Fig. 4)

A final X-ray which was done 37 days later on May 19th was reported thus; "The previous collection noted in the left hemi-uterus, where there was a sac-like formation has apparently emptied completely."

*Dr. Emanuel W. Benjamin, of Providence, R. I.

Comment

A uterine anomaly of the deficiency type, a bicornate uterus with a rudimentary horn, appears to be present. The fact that the rudimentary horn did not empty readily may be due to the narrowness of the bore of its canal, or to the undeveloped musculature of its walls.

Suspicion of the anomalous condition of the internal genital apparatus of a 14 year old girl was directed to it, first, by the disclosure of an absent kidney, and second, by the occurrence of a menstrual episode with passage of retained menstrual discharge and relief from abdominal pain. And indirectly, and later, by the mother's miscarriage of a fetus born with a form of agenesis.

The genital system should always be investigated if there is a known anomaly of the urinary organs, and the reverse statement holds as well.

Emphasis is made of the satisfactory results in most cases of diagnosing genito-urinary conditions by means of X-ray. Uterosalpingography, especially when spot films[5] are made of the fractional injections of the opaque medium under fluoroscopic control, is probably the best method today for diagnosing uterine structure.

Neither bimanual examination nor the use of the culdoscope[6], a valuable method for diagnosing pelvic pathology, can give the information regarding exact anatomical variation of structure as can be obtained by hysterosalpingography.

Summary

The report of a case of uterine malformation with kidney agenesis and a method for its diagnosis has been presented. The diagnosis of a uterine abnormality, especially of the type reported here, if made before complications arise, should result in better chances for the patient's safety.

References

[1]Novak, Emil: Gynecology and Female Endocrinology, Boston, 1941, Little Brown & Co., p. 97.

[2]DeLee, J. B. & Greenhill, J. P.: Principles & Practice of Obstetrics, Philadelphia, 1947, W. B. Saunders Co., p. 474.

[3]Williams, J. W.: Obstetrics, New York, 1925, D. Appleton & Co., p. 639.

[4]Graves, W. P.: Gynecology, Philadelphia, 1929, W. B. Saunders Co., p. 555.

[5]Hyams, M. N.: Uterosalpingography by Interrupted Fractional Injections, Surg., Gynec., & Obs., 60:224, 1935.

[6]Telinde, R. W. & Rutledge, F.: Culdoscopy, a Useful Gynecologic Procedure. Am. J. Obst. & Gynec. 55:102, 1948.

PATRONIZE JOURNAL ADVERTISERS

THALASSEMIA MINOR

A Report of Ten Cases

A. M. PHILLIPS, M. D., W. A. LEONARD, M. D., and
HERMAN A. LAWSON, M.D.

The Authors. A. M. Phillips, M.D., Former Resident in Medicine; W. A. Leonard, M.D., Resident in Medicine; Herman A. Lawson, M.D., Formerly Chief of Service, Department of Medicine — all of Rhode Island Hospital, Providence.

RECENTLY we have observed ten individuals who were found to have the characteristic clinical findings which are associated with the diagnosis of Thalassemia Minor or Mediterranean anemia. Six of these were patients observed in the hospital. Two were sisters observed by one of us (H.L.) in private practice, the father of these girls, and the tenth was a brother of one of the hospitalized patients.

Cooley and Lee[1] in 1925 separated the classical form of the disease from the complex known as von Jaksch's disease. The classical form is characterized by hypochromic microcytic anemia, splenomegaly, typical facies and a racial and familial tendency. It is now known as Cooley's anemia, Mediterranean anemia or Thalassemia Major. Patients with this form of the disease usually do not live beyond puberty.

Since the description in 1940 by Wintrobe[2] and Damashek[3], a relatively milder form of the disease has been recognized and termed Thalassemia Minor. The clinical picture in these patients is that of hypochromia and microcytosis of the red blood cells with or without slight anemia and also occasionally associated with abnormally high red cell counts. Stippled, target and oval cells, quite out of proportion to the degree of anemia, are the morphological abnormalities seen in the red corpuscles. The resistance of the red blood cells to hemolysis in hypotonic saline solutions is increased. The anemia is refractory to iron therapy and the patient is usually of Mediterranean ancestry. Splenomegaly and slight icterus may be present.

The pathologic physiology involved is apparently an inherited defect in hemoglobin synthesis resulting in red blood cells which contain a little substance but adequate membrane so that they can absorb more fluid than normal cells[4] without bursting. Due to their thinness, they appear as the bizarre forms previously described.

Both the major and minor forms of the disease are inherited. The exact mechanism is not clear, but the inherited factor may be either an incomplete recessive or semidominant gene[5]. In a heterozygous individual Thalassemia Minor is produced. The homozygous individual suffers from the major form of the disease.

That the Mediterranean anemia syndrome is not of rare occurrence, is brought out by the survey in Rochester, New York[6] of persons of Italian descent in which the major form of the disease was present once in 2,368 births and the minor form once in each 25 persons. Other reports substantiate the frequent occurrence[7, 8].

Case Reports

CASE #1—C. S. was a 55-year-old Italian female who was admitted with vague abdominal pains and pains in both legs of one week's duration. She appeared well-developed and well-nourished, but pale. Physical examination was completely negative. There was no splenomegaly demonstrable. Her hemogram is shown in Table I. Decreased RBC fragility was demonstrated and a bone marrow aspiration revealed immature erythroblastic hyperplasia. Blood chemistries were within normal limits. No source of blood loss could be demonstrated.

CASE #2—E. S. was the 17-year-old son of C. S. who was admitted with a three-day history of pyrexia, chills, malaise, sore throat, sweating, nausea, vomiting and a harsh hacking cough. Physical findings were consistent with a right lower lobe pneumonitis of viroid etiology. This finding was confirmed by chest x-ray. The spleen was palpable at the costal margin. Sputum cultures were negative for acid fast bacillus. No evidence of blood loss could be demonstrated. Repeated hemograms revealed findings similar to those shown in Table I. His recovery was uneventful.

CASE #3—A. C. was a 76-year-old Italian male admitted to the Urological Service for suprapubic prostatectomy for benign prostatic hypertrophy. History was poor because of language barrier, but

continued on next page

in addition to urinary symptoms he complained of weakness and vague abdominal distress over a prolonged period of time. There was no evidence of blood loss including a negative G.I. series. Physical examination revealed splenomegaly, the spleen being palpated at the costal margin. Repeated hemograms revealed persistent hypochromic microcytic polycythemia as shown in Table I.

Case #4—E. M. was a 27-year-old white female of Italian extraction who was hospitalized for observation because of weakness and easy fatigue. Prior to admission she had been found to have a hypochromic anemia. Examination disclosed slight pallor of the skin and that the edge of the spleen was easily palpable at the costal margin. Work-up failed to disclose any pathology. This included x-rays of the gastrointestinal tract. Blood counts repeatedly showed hypochromic anemia. She has been followed for nine months since discharge with persistence of hypochromia despite iron therapy. Her latest hemogram showed 6.11 RBC, 10.6 grams hemoglobin, giving a color index of 0.58. Stained smears have persistently contained moderate poikilo- and anisocytosis with oval and target cells.

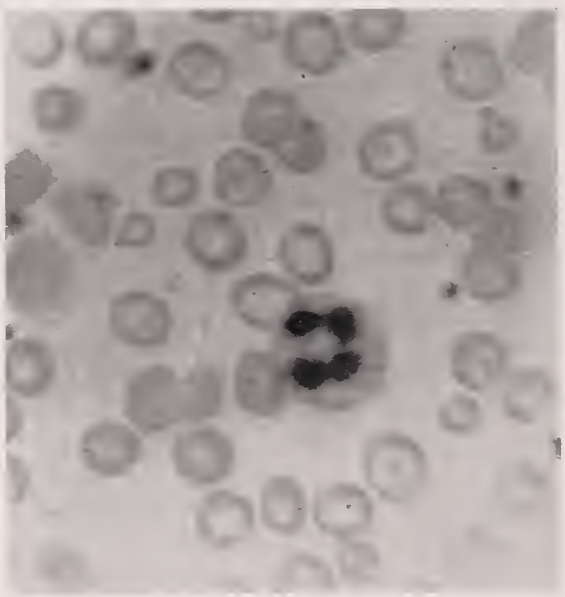


FIG. 1 Smear from Case No. 4 showing Target Cells, poikilocytosis and anisocytosis.

Case #5—R. E. was a 29-year-old married sister of E. M. She had been in good general health and had no complaints. Examination revealed slight pallor of the skin and a palpable spleen at the costal margin. Report of hemogram is included in Table I.

A second sister of E. M. was examined and no abnormalities were found. Her blood count was 4.38 million RBC and 13.0 grams of hemoglobin, giving a color index of 1.0. Stained smear was in marked contrast to her sister's in that there were no target, oval or stippled cells and that the red blood cells were uniform in size and shape.

Table I

Patient	Rbc	Hgb	C.I.	Wbc	Smear	Spleen	Rbc Fragility
C.S.	5.76	11.0	0.65	5600	✓	0	Decreased
E.S.	8.70	15.0	0.59		✓	✓	
A.C.	7.12	10.0	0.48	7700	✓	✓	Decreased
E.M.	5.69	9.7	0.57	12000	✓	✓	
R.E.	6.01	11.0	0.61	8000	✓	✓	
A.P.	5.00	12.5	0.86		✓	0	
F.M.	5.90	13.0	0.63	6000	✓	0	Decreased
E.X.	6.95	14.0	0.66	5000	✓	✓	Decreased
A.Z.	4.80	11.4	0.79		✓	✓	Normal
S.B.	8.09	13.2	0.45	7100	✓	✓	Decreased

Case #6—A. P. was a 50-year-old brother of C. S. who was in good health and whose hemogram was done at our request and is shown in Table I. Examination was completely negative.

Case #7—F. M. was a 52-year-old Italian professional man, father of E. M., and R. E., who enjoyed excellent health except for occasional discomfort at the site of a previous thoractomy of his left chest for empyema. A complete hemogram was not done at the time of admission for this procedure thirteen years previously. He was examined presently, as well as his wife, to determine which one transmitted the trait. His hemogram is shown. That of the wife was entirely normal as was her RBC fragility. His spleen was not palpable through a somewhat obese abdomen. There was no history or present findings suggestive of blood loss.

Case #8—E. X. This 55-year-old male native of Greece was known to have had bronchial asthma and unexplained splenomegaly since 1933. No record was obtainable pertaining to the hemogram at that time. Except for minimal pulmonary findings referable to his bronchial asthma and a definitely palpable spleen, his physical examination was essentially negative. There was no clinical or laboratory evidence of blood loss. His smear revealed moderate anisocytosis and a less marked degree of poikilocytosis. It was somewhat unusual for its very numerous tailed, pencil and other bizarre forms. Occasional stippling was seen and target cells were obvious. His hemogram recorded in Table I and smear were considered consistent with Cooley's trait.

Case #9—A. Z. This 22-year-old Syrian male was admitted with a three-year history of recurrent attacks of RUQ pain and icterus. Eight months

prior to this admission he had a cholecystectomy for cholelithiasis and common duct stone. This procedure was done at another hospital and the composition of the stone could not be ascertained. Since his surgery, he had three attacks of colicky RUQ pain and icterus. He was admitted for investigation. Examination revealed a sallow complexion and the spleen one fingerbreadth below the costal margin. The liver was not palpable. The hemogram is shown. His smear revealed 4+ stippling, poikilocytosis and small oval cells but rare target cells present. There was no increased cellular resistance demonstrated. Liver function tests were all within normal limits. Serum bilirubin 3.4 milligrams. The urine was negative for bile and urobilinogen was positive in dilution 1:80. There was no clinical evidence of blood loss. Complete gastrointestinal roentgen series were negative and there was no evidence of common duct stone either by x-ray or duodenal drainage.

Case #10—S. B. This 25-year-old Greek male was admitted for investigation of unexplained splenomegaly found on a routine physical examination. He had always enjoyed excellent health and systemic review was entirely negative. The only positive physical finding was a spleen palpable two fingerbreadths below the costal margin. His hemogram is shown. The differential was normal with no atypical cells observed. Moderately marked achromia was seen as well as occasional stippling. Red cell fragility was decreased. All other diagnostic procedures were negative.

Discussion

Ten cases of Thalassemia Minor are reported from the city of Providence. In view of the relatively large Mediterranean population particularly of Italian descent, it is to be expected that the disease is of common occurrence. Familiarity with the classical findings usually present in this disease will enable the physician to accurately diagnose patients presenting hypochromic anemia or polycythemia and otherwise unexplained splenomegaly.

The differential diagnosis includes anemia due to blood loss, lead poisoning, liver disease and other causes of splenomegaly.

Summary

Ten cases of Thalassemia Minor are described. The frequency of the syndrome is emphasized.

Bibliography

[1] Cooley, T. B., and Lee, P.: Series of Cases of Splenomegaly in Children With Anemia & Peculiar Bone Changes. Trans. Am. Pediat. Soc., *37*, 29, 1925.

[2] Wintrobe, M. M., Matthews, E., Pollack, R., and Dobyns, B.M.: A Familial Hemopoietic Disorder in Italian Adolescents & Adults. Four. Am. Med. Ass'n., *114*, 1530, 1940.

[3] Damashek, W.: Target Cell Anemia, Erythroblastic Type of Cooley's Erythroblastic Anemia; Am. J. Med., Sc., *200*, 445, 1940.

[4] Wintrobe, M. M.: Clinical Hematology; 2nd Edition Lee & Febiger, Phil.

[5] Valentine, W. M., Neil, S. V.: Hematologic & Genetic Study of the Transmission of Thalassemia; Arch. Int. Med., *74*, 185, 1944.

[6] Neil, S. V., and Valentine, W. M.: The Frequency of Thalassemia; Am. J. Med. Sci., *209*, 568, 1945.

[7] Smith, C. H: Familial Blood Studies in Cases of Mediterranean (Cooley's) Anemia; Am. J. Dis. Child. *65*, 681, 1943.

[8] Silvestroni, E., Bianco, I.: Quoted in Wintrobe, M. M., Clinical Hematology, R 565.

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THE PRACTICE OF MEDICINE IN THE FUTURE*

JOHN F. KENNEY, M.D., F.A.C.P.

The Author. *John F. Kenney, M.D., F.A.C.P., Former Chief of Medicine and Director of Laboratories and Tumor Clinic, The Memorial Hospital, Pawtucket, R. I.*

This paper was prepared by the late Dr. John F. Kenney for presentation to the Bristol County Medical Association on March 21, 1950. Doctor Kenney died on March 20, and it is the wish of the Bristol County Medical Association, and of the Editorial Staff of the *Journal*, that the talk Dr. Kenney was to have delivered be published. — *The Editor.*

I HAVE chosen this subject because never in the history of medical practice, at least in this country, has there been so much talk and apprehension on the part of the public, the government and medical profession.

We hear names given to the future practice such as state medicine, socialized medicine, etc. Whatever the name given it—it is an established fact that the methods in the care of the sick are changing. A few examples: Blue Cross has been doing a successful job in paying hospital bills, and for a group, that we as physicians have been claiming were pinched in between. We have long maintained, and it is a fact that the wealthy could afford any hospital or diagnostic procedure, and the indigent obtain the same care free.

Any physician or nurse on a hospital staff will show you a chart of either of these two types of patients, filled with reports of consultations, and every laboratory and diagnostic procedure. The first group paid for it, and the latter received benefits of ward rounds, consultations, operations, etc., free or possibly part paid through a city grant, or otherwise, but in any case free insofar as the individual was concerned.

Now, the in between or middle class patient is coming into his own through Blue Cross and prepayment medical and surgical plans, for a sum, not too large per year, as compared to complete bills, doctor, hospital, and diagnosis, etc., rendered in the past. They are certainly small in regards to the high cost of hospital care at present.

*Prepared for presentation to the Bristol County Medical Association at its meeting at Warren, R. I., March 21, 1950.

Patients are becoming hospital conscious and demand entrance into hospitals due to a number of factors. Nursing care is important in carrying out doctor's orders, and it is impossible at present standards of living for a middle class patient, and certainly not an indigent patient, to afford a three nurse shift for very long without a severe dent in the bank account.

Then, again, people are living in smaller quarters, both apartments and small homes, where even isolation and proper care cannot be carried out. Then, the physician needs the various diagnostic procedures such as x-ray, E. K. G., metabolism or laboratory tests, typing, etc., even though after admitting a patient he may not use them. Rather than wait several days at home for symptoms to develop, that a diagnosis may be made clinically, he anticipates these procedures and many times by a quick and accurate diagnosis saves the patient a long illness or complication in a hospital, and perhaps saves a life.

Many physicians are clever at clinical diagnosis and perhaps their pre-practice training has been longer and better than some of their colleagues, but we all know that with the newer diagnoses and treatment and present medical school training the average doctor would be lost without laboratory facilities. This is one great complaint that the young trained doctor leaving medical school has against starting a country practice too far away from a medical center or good hospital facilities.

About Government Medicine

We hear Mr. Oscar Ewing tell about the advantages of government control of medicine and Governor Harold Stassen's admirable description of what it has led to in England in the short period it has been in force, but how often do you hear our own medical men evaluate what the government, national or state, have already under control? We will mention a few.

First, veterans hospitals take a large number of doctors to staff them, and they are controlled and under the pay of government.

In our own state, we have directors of various departments, such as child welfare, industrial medicine, a full time position as director of cancer, a bill recently put through for a full time medical

examiner, a rehabilitation director. We have full time residents at the state hospitals, as well as the directors of these various institutions. We have full time chest doctors either under state or local agency pay, and in the near future we can expect the possibility of heart and arthritic foundations, with full time staffs, and the possibility of other chronic diseases treated or controlled the same way.

So here we are gradually assuming a government controlled medicine in a different way but to my opinion the proper way. These agencies that I have mentioned all have high type men in not only the directorships, but in the subordinate positions as well; for example, the high standards set up for the medical staffs of the veterans hospitals. All this has a tendency to limit the field of general practice. The veterans run into the millions, and it will be only a short time when you will see the number markedly increased by the addition of veterans' families. So, if the government is not too hasty in putting over its socialized program, all they will have to do is wait a little longer and it will all be done for them.

The welfare program could not be started at this time because of the shortage of physicians. This shortage is still relatively acute, started during the last few years by first medical schools suddenly stopping the accelerated program, second, retention of medical men in the service, and taking into the various armed service hospitals of a large number of graduates that are kept out of civilian practice for some time. Third, most important, the establishment of residencies in hospitals, thus making it above five years after graduation from medical school before starting practice. Fourth, taking from private practice a number of physicians to staff the various V. A. hospitals and agencies.

There have been a few new medical schools started together with the existing medical schools increasing slightly the number in each class. These facts with what is happening in our own locality, that is, the addition of hospital beds at all hospitals, facilitating easier care, will eventually strike a balance where the patient load per doctor will equalize itself.

The problem of locating doctors in country practice is not of such import in Rhode Island but could be helped in many states where there is a shortage by subsidy, state or country building and maintaining small hospitals or diagnostic centers, a pooling of communities to accomplish this, but above all for the citizens of these areas to realize that to raise a family and give them what the families are obtaining, or have access to, in larger cities, has considerable to do with a doctor locating in these rural areas.

Specialty Boards

A few years back, the specialist in medicine or surgery frequently established himself by the fee he charged in excess of what the general practitioner received. The need for a change was recognized and the College of Surgeons and College of Physicians was started and standards and requirements for membership were set up after a founding body was taken in. This worked for a time but the specialists who strictly confined themselves to a limited field decided that something more drastic was needed and the various specialty boards came into being. There has been much criticism by the members who by reason of years in practice are regarded by other members of the profession as well qualified, who hold leading positions on the various hospital staffs, but for some reason or other will not take the examination, or for some technicality are not eligible.

The younger men are told by the professors in school to get out into general practice but the subjects given the students are all by specialists. In the recent war the specialists with board training received the best assignments. Even at our local level the hospitals are establishing residencies. Our largest hospital had over one hundred applicants for internes. Probably because each man felt it would put him in line for a residency when his interneship was completed.

Several hospital staffs have a rating committee that evaluate the various members of the staff and qualify him, only letting him do certain specialties and advance him in this field as he receives more training or demonstrates more proficiency. This overseeing by the staff, while it is an excellent thing, still has the young man aspiring for a specialist berth.

So, in conclusion—we hear that 80 per cent of the ills may be treated by a general practitioner and we now have an academy of general practice but changing conditions, Blue Cross, surgical plan, various agencies, and the demand in the past of the patient either going to a specialist direct or demanding that his physicians send him to one or to a clinic is gradually narrowing the field where the general practitioner may use his knowledge, no matter how well trained he is.

The public will have to be re-educated that the general practitioner can still treat the large percentage of ills, and hospitals will have to readjust the staff rules to make a place for these men, naturally keeping up the high standards and hoping that the government will recognize the high standards that the profession has set for itself both in and out of hospitals; subsidize certain areas if necessary but do not tear down or destroy the system of medicine that has given us the best health of any country in the world.

RESOLUTIONS *In Tribute To The Late* JOHN F. KENNEY, M.D.

President of the RHODE ISLAND MEDICAL SOCIETY, 1945-1946

RESOLUTION ADOPTED *by the* RHODE ISLAND GENERAL ASSEMBLY

WHEREAS, Upon Monday evening, March 20, 1950, there died John F. Kenney, M.D., a loss to the State of inestimable value because of his vast experience and public achievement, the General Assembly now records its tribute of appreciation for the valued contribution to official medical and public health records in Rhode Island.

Dr. Kenney was born January 5, 1890 in New Bedford. He graduated from Mosher Academy, New Bedford; from Tufts Medical School, *cum laude*, in 1913, and interned for 3 years at the Rhode Island Hospital.

In his crowded years, Dr. Kenney held many posts. Among them were these: President of the Rhode Island Medical Society; member of the advisory board and consultant at Memorial Hospital; founder of the Dr. John F. Kenney Tumor Clinic; also former chief of the medical department at Memorial Hospital and former laboratory chief; member of 2 State Boards in his field and consultant at 7 hospitals in this area; appointed to the committee investigating conditions at the state infirmary at Cranston; member of the basic science board of the state of Rhode Island and the advisory board of the Rhode Island curative center; former President of the industrial physicians and surgeons of New England; fellow in the American college of physicians; diplomat of the American board of internal medicine (Fellow in 1933) and a life member of the American Medical Association.

Dr. Kenney was a communicant of St. Mary's Church and a member of the Holy Name Society there. He was a member of Delaney Council, Fourth Degree, Knights of Columbus; now therefore be it

RESOLVED, That the members of the General Assembly, awed with the summary of the responsibilities indicated in these many high offices, now expresses its heartfelt appreciation for the calibre of this professional healer, whose indefatigable efforts to help mankind and conscientious devotion to duty have taken an early toll of his years; extending to the widow and family of the late John F. Kenney, M.D. sincere sympathy in their loss; directing the Secretary of State to transmit to them a duly certified copy of this resolution.

RESOLUTION ADOPTED *by the* COUNCIL *of the* NEW ENGLAND STATE MEDICAL SOCIETIES

WHEREAS Doctor John F. Kenney, of Pawtucket, Rhode Island, did invite the state medical societies of New England to send representatives to Providence, Rhode Island, on July 18, 1945, to consider the formation of a conference group to bring about a closer cooperation between the Societies in the development and maintenance of the highest standards in the conduct and the administration of medicine, and in the furtherance of plans to improve the health of all the people in the New England States, and

WHEREAS this meeting resulted in the formation of the Council of the New England State Medical Societies, of which Doctor Kenney served as its first vice president, therefore be it

RESOLVED that the members of the Council assembled for their fifth annual meeting this day, April 19, 1950, at Boston, Massachusetts, do record their deep appreciation for the pioneer work that Doctor Kenney did for the Council, and do extend to his widow and family their sincere sympathy in his untimely death on March 20, 1950.

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MALPRACTICE EVIDENCE

MALPRACTICE has been defined by Regan as "the failure on the part of a physician or dentist properly to perform the duty which devolves upon him in his professional relation to his patient, a failure which results in some injury to the patient.

Thus, malpractice has two essential parts to it: first, that the physician fails to do his duty; and second, that definite injury to the patient is the result of his failure."

In elaborating on this definition with its twofold aspect Regan calls attention to the fact that this legal duty, arising as a matter of law out of the physician-patient relationship, requires "that the physician undertaking the care of patient possess and exercise that reasonable and ordinary degree of learning, skill, and care commonly possessed and exercised by reputable physicians practicing in the same locality, or in similar localities, in the care of similar cases; it requires also that the physician, in caring for the patient, exercise his best judgement at all times."

Medicine is not an exact science but is constantly changing in theory and practice. Sound induction of yesterday may well be obsolete and proved erroneous today. For example, successive editions of the same living author may well take different positions on the same subject and to allow an earlier opinion to be admitted as evidence would under these circumstances misrepresent the author's opinion on the subject.

Therefore, the action of the Senate Judiciary committee of the General Assembly is to be commended in not approving the act proposed to it last month to provide that a statement of fact or opinion on the subject of science or art contained in a published treatise, periodical, book, or pamphlet shall, in the discretion of the court, be admissible in actions of contract or tort for malpractice, error or mistake against physicians, surgeons, dentists, hospitals, and others.

Statements contained in medical books cannot be used in evidence, and counsel may not read to the jury from such books. This rule is subject to an exception as noted by Regan. When a witness refers to a treatise as corroborating his testimony, or bases his opinion thereon, the witness may be cross-examined as to the contents of the book. But if the physician testifying as an expert has not referred to any book, or named any book as an authority, or one on which he relied, it is not competent on cross-examination to go into the contents of medical books.

The statute proposed for Rhode Island would have imposed an extreme penalty upon the physician, dentist, optometrist or hospital. It would have deprived a defendant of an opportunity to cross-examine the author of the statement or opinion, thus making it impossible to test the accuracy and weight to be given such declaration. Since authors do not write under oath, the grounds of their belief

continued on next page

and process of reasoning could not be tested had the Rhode Island proposal been adopted.

Consider also the fact that extracts from medical books on the subject of science or art may be based on the unsworn statement of others beside the author, thus rendering such evidence of extremely dubious value. Consider the misinterpretation that might be effected, the resultant jury confusion, by the introduction of technical statements from scientific texts.

The incidence of malpractice in Rhode Island has been minimum. We are proud of the high standards maintained by our members. We have for many, many years had a committee on medical defense and grievance in the Society whose task it has been to hear complete testimony on any alleged error or malpractice charged against a physician, and to act honestly and impartially on the evidence presented.

We believe that our members endeavor to care for every patient with meticulous attention to the requirements of good medical practice. But we know that the physician may be sued unjustifiably by any patient despite anything and everything he may do. His defense is difficult enough without imposing such provisions against him as the use of opinions expressed in periodicals, books or pamphlets, as was proposed to the Assembly.

INSURANCE — AND THE COST OF GOVERNMENT

We have recently read annual statements from several large life insurance companies. Two interesting factors stand out in these reports. One is the tremendous growth of life insurance—with an estimate of eighty million policyholders in this country — and the second is that interest rates on investments continue to be low.

We in America have always been proud of the fact that the majority of us are thrifty, that we are willing to save from our current income through insurance in order to protect in some measure our individual futures. We certainly have reason to be concerned now that this incentive to save is being weakened generally by the continual increase in the cost of government.

Through the mechanism of the central banking system it has become the policy of the Government to keep interest rates low in order to borrow at as low a cost as possible the funds necessary to operate the tremendous ramifications of the government system, and to cope with the national debt. Thus interest rates cannot maintain the necessary balance between the supply of savings for investment and the demand for investment funds.

The Hoover Commission report put its finger on many of the faults of our expanded government activities which have siphoned off through taxes what might otherwise have been held by the individual as savings to be invested as he desired. The incentive to earn more, and to save, has thus been seriously weakened, and all the while increased government spending has lowered the purchasing power of money.

Eighty million people can't be wrong. But they can be fooled; only for a time, we sincerely hope. The invested savings of the people in insurance provided the capital that has created the industrial greatness of America which in turn has guaranteed work for the individual and reserve funds to protect adequately his life savings, whether in savings deposits or insurance.

The medical profession of this country has spearheaded a frank and open campaign of public education on the dangers inherent in the paternalism of government. The insurance industry has an obligation to take an equally aggressive position to bring forcefully to the attention of its eighty million policyholders the necessity for strict economy in every department of government, and the restriction of government within the confines of the legitimate duties for which it is established.

TUBERCULOSIS CONTROL

The annual report of the Providence Tuberculosis League is most encouraging to all engaged in the never ending battle against disease. Ten years ago there were 111 deaths from tuberculosis in the city of Providence. In 1948 there were 85, and last year there were 70.

The decline in mortality does not always indicate a decrease in the morbidity, as Dr. U. E. Zambarano, medical director of the League, has pointed out. The fight is not over, and there is still much tuberculosis that remains undiscovered and untreated. Control work goes forward, combating fear and ignorance on the way, and striving to bring the facilities available for diagnosis and treatment to the attention of everyone.

As Doctor Zambarano states in his annual report, "the most important factor in the control program in the future is the family physician." He will always be the first line of defense in all health activities, and his alertness will be the major factor in detecting tuberculous cases in the minimal stages.

PUBLIC LAWS

Ten years ago the General Assembly enacted the basic science law which in the intervening time has done much to raise the standard for licensure in Rhode Island for all who aspire to practice the healing art. The recent session of the Assembly was given a proposal that would result in a weakening of this law. That the Assembly would reject the proposal was to be expected by anyone appreciative of the importance of maintaining the highest possible standards for all physicians and dentists.

The amendments proposed would have allowed the candidate to receive less than 75% in two subjects, instead of one as now provided, would have eliminated examination of candidates in the laboratory should the board deem such tests necessary, and would have diluted the pre-professional academic education requirement by allowing the candidate to offer "educational qualifications equivalent thereto." Just what is equivalent to a year of pre-professional collegiate education in an academic college remains a mystery.

Instead of being weakened, the basic science law should be strengthened. In the light of present day practices and training it would seem that the pre-professional educational requirement might well be made two years instead of one.

The enactment of amendments to the medical examiner law which do not carry out the recommendations of the special committee of the Society which gave much thought to the problems that arose as the result of the statute enacted a year ago, will hardly satisfy all who have been concerned. The joint committee of the bar association and the medical society served in the best interest of the state, and when their recommendations were only partially met a year ago it was readily apparent that the law would require further changes this session. The sub-committee of the Society, headed by the late Dr. John F. Kenney, offered what seemed a good solution to the problem, proposing utilization of the facilities of the Chapin hospital, and allowing the state medical examiner to be affiliated with that institution. The Assembly, however, has seen fit to solve the matter in its own way. We sincerely hope that the solution proves satisfactory.

THIRD GERBER ORATION

On April 19 there was held the Third Annual Isaac Gerber Oration under the auspices of the Miriam Hospital Association. Dr. Garlock of the Mount Sinai Hospital, New York City, gave a brilliant talk on surgery of the esophagus, a subject on which he is easily a leader.

There is no doubt that the startling and brilliant advances of surgery during the last few years have been mostly confined to the chest cavity. We say surgical advancements, but all these able surgeons point out that the advancements are due to the perfection of teamwork between themselves, internists, anesthetists, physiologists, and house and nursing staffs. It is a beautiful demonstration of what teamwork can do in medicine.

Probably these orations are not absolutely unique but it must be rare to have a living man so honored. Dr. Gerber accepts this distinction in a most graceful manner. We are looking forward to joining with him in many more of these delightful occasions.

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CHARLES J. ASHWORTH, M.D.

of Providence, R. I.

President of the Rhode Island Medical Society

1950-51

PRESIDENT'S MESSAGE

A NEW PERSPECTIVE with its shift in values has been forced upon us following the recent war projecting responsibilities for the future no less than the present. Regardless of how objectively we try to present to ourselves the data of recent history, it is increasingly difficult to become separated from a point of view that must in the last resort be our own. This is not only natural but justifiable when scrutiny discloses that position to be evolved from truly Aesculapian tradition and set securely upon Hippocratic principles.

The seemingly insurmountable difficulties of a year ago have to a very great degree been leveled, but as we look forward again we see still other challenges that must be met and with equal success. This assurance stems from past accomplishment rather than from future hope. Persecution of our profession appears to be as necessary as pruning to an orchard, and no less effective. In the response that recent threats to the integrity of the art and the freedom of the practice of medicine have evoked, the profession has addressed itself to the task of integrating the economic, therapeutic, and social needs of our people.

Present day demands for interchange of social ideas have led to an increase of ideals which when put into action become motive forces with power directly proportional to the increase in knowledge resulting from such interchange. An effective ideal arises only from perception and recognition of a definite evil, and reform, not reaction, is the logical sequence, although different plans for reform may originate in the enthusiasm of an ideal. The common ideals of the present are the result of a gradual development to meet with existing evils, thereby planning a better future. While some of these are as old as civilization, others are due to forces which have come into existence only recently and the proper correctives must be developed in the light of this new and brief experience.

Observation of the success of contemporary efforts by groups not unlike the medical profession has revealed one underlying factor varying in degree but common to all. This has been unity. Personal differences, class distinctions, levels of rank, and other divisible components which tend to separate have been put aside for the purpose of securing a good objective. Individual sacrifice of both rights and privileges has resulted in a bond of strength, the force of which is measurable only by the accomplishment of the ends sought.

This unity which is so desirable in our ranks today and which has been achieved by others with a similar identity of purpose, is a simple notion but incapable of definition. That which is said to be one is undivided in itself. It is this undividedness which is so essential to the perpetuation of medical art cloaked as it is in the tradition of sacrifice and service to mankind. While we may be divided by many factors, racial, religious, material or political, we can as an organized profession rise above all these distinctions, now, as in the past.

Daily intimate contact with realistic problems may well obscure high ideals and noble purposes, but it becomes increasingly obvious that this unity of effort must not be lost sight of in the struggle against ignorance and prejudice.

Confronting us in the immediate future is the culmination of the first year of Rhode Island Medical Society's prepaid medical and surgical care plan so auspiciously begun under the direction of Physicians Service and merchandised by Rhode Island Blue Cross. The continued cooperation of each member of the state society will guarantee its success just as it has insured its beginning.

Similarly, the expansion of our public relations program will be a major item of accomplishment not only for the local improvement in a better understanding of our objectives with their inherent responsibilities to the public we serve, but also as a part of the national effort to extend in the needed areas the benefits of medicine's steady and ever increasing advances for the benefit of all.

The extension of better emergency coverage to other areas of the state which the operation of the new medical bureau in Providence has so ably demonstrated is possible, is another project which this year will demand and I know will receive the unity of purpose necessary for its complete success.

These then are but a few of the goals toward which our state society strives in this coming year. No word of exhortation is necessary to secure them other than to emphasize the meaning of and need for that concept of indivisibility connoted in the term unity.

May we emerge under the leadership of a new administration, confident in the determination to maintain unbroken the cherished traditions that have been exemplified so illustriously by all my able predecessors.

CHARLES J. ASHWORTH, M.D., *President*



ROBERT T. HENRY, M.D.

of Pawtucket, R. I.

Vice President, 1950-51



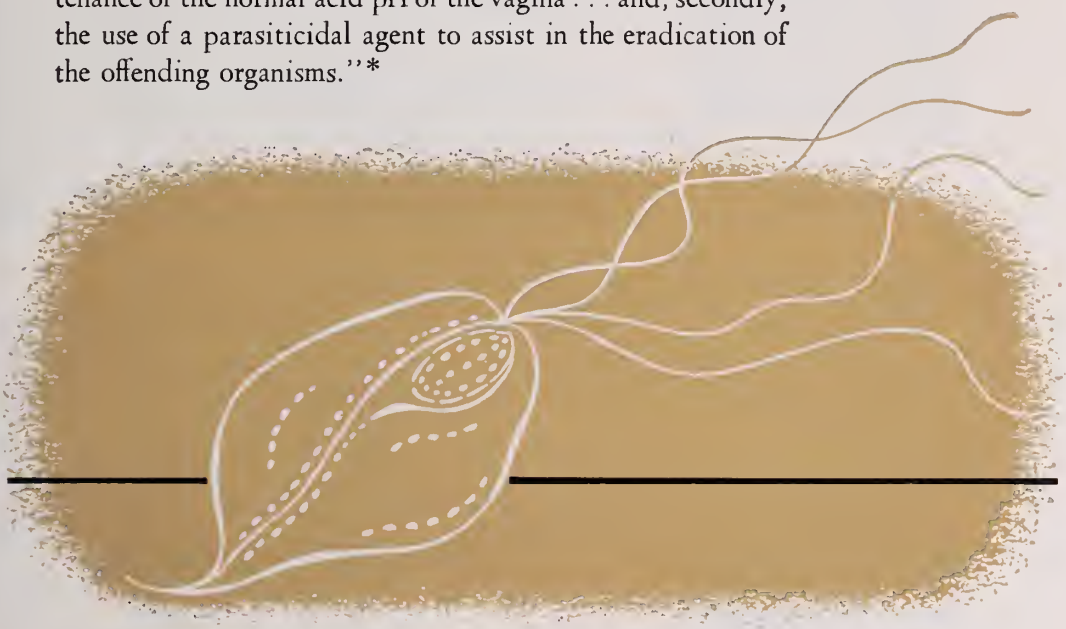
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*Hardy, J. W.: Office Gynecology, J. Missouri St. M. A. 45:811 (Nov.) 1948.

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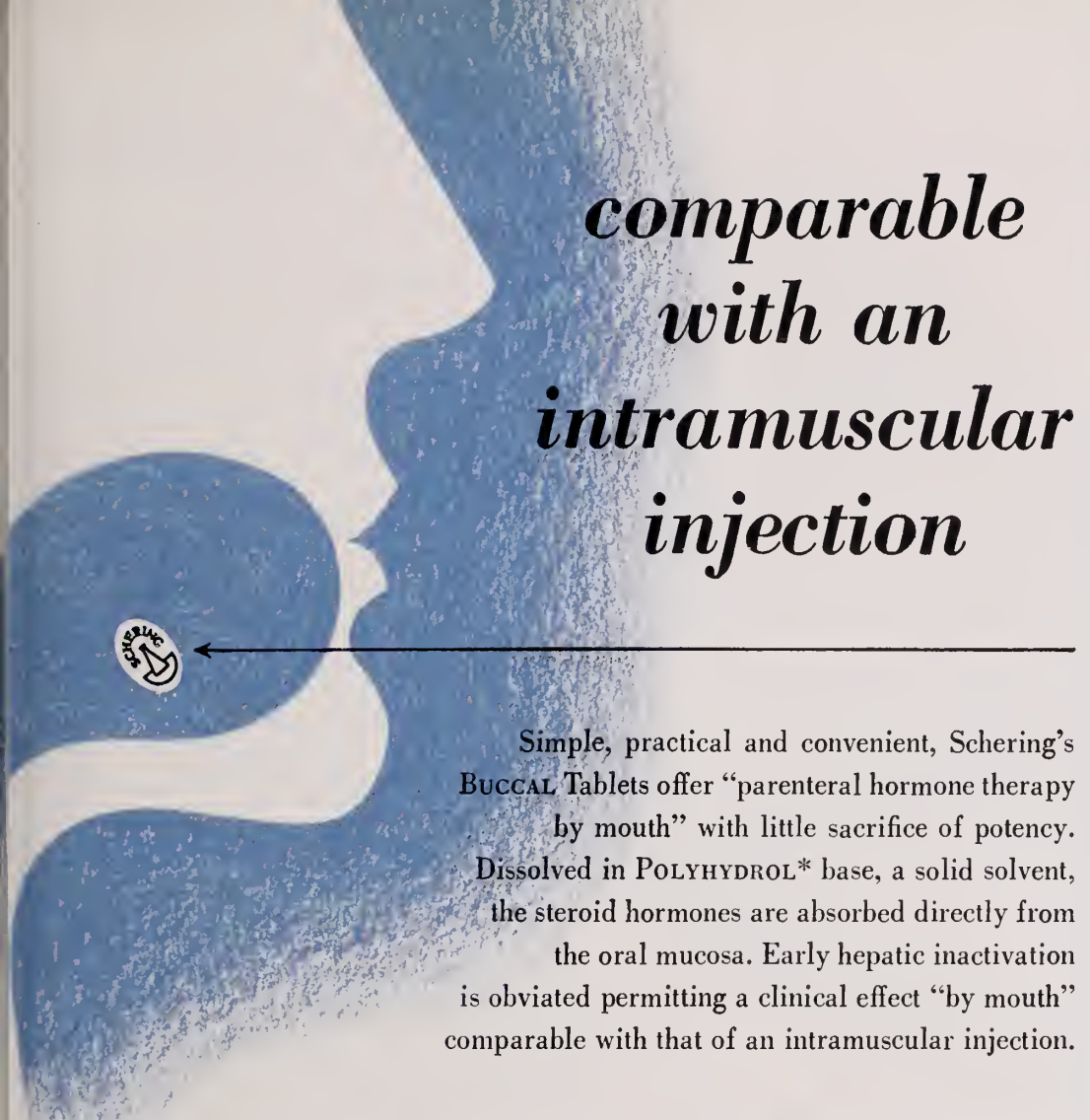
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In doses of 25 to 75 mg., administered either orally or parenterally, Priscoline "usually is tolerated with few side effects."[3]

Comprehensive literature on request.

1. Rogers, Max P.: J.A.M.A., May 21, 1949
2. Wyatt, Bernard L.: Ann. West. Med. & Surg., Aug. 1949
3. Grimson, Marzoni, Reardon & Hendrix: Ann. Surg., 127:5, May 1948

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DISTRICT MEDICAL SOCIETY MEETINGS

BRISTOL COUNTY MEDICAL ASSOCIATION

A regular meeting of the Bristol County Medical Association was held on Tuesday, March 21, 1950, at the Martin Home in Warren, Rhode Island.

The minutes of the previous meeting were read by the secretary and were approved as read. A few comments and explanations were necessary for those who did not attend the February meeting, when the subject of "Arthritis and the Use of Cortisone" was presented by Dr. Earl E. Hussey.

A report from the Department of Health, signed by Miss Catherine D. Tracy, R.N., Nursing Director, was read. The substance of this report was to the effect that Public Health nurses should not be allowed to give "certain potent drugs intramuscularly" without an order from the local doctor—"A Rhode Island licensed physician." The letter was filed.

A letter addressed to the president of the Association was presented proposing the establishment of a cardiac clinic in Bristol county for the benefit of children with rheumatic heart disease. At present the children coming under the State Rheumatic Fever Program have to travel by bus or car to one of the Providence Hospitals for their examinations and electrocardiographs. This service would be available to anyone up to 21 years of age who is referred by the local physician. The district nurse, Miss Tanner, reported that at present there are ten children being cared for, four from Barrington, and six from Warren. The letter was placed on file for future consideration.

Dr. Henry B. Fletcher reported that Dr. E. K. Landsteiner was going to attend a meeting for the study of Atomic Medicine at Rochester, New York, this week. He was to be a delegate from the Rhode Island Medical Society.

The various members reported that they have not yet received bills for their annual dues, and also that the treasurer has not paid some of the accounts outstanding. The secretary was informed to call this matter to his attention.

The subject of the March meeting was to be "The Practice of Medicine in the Future" and the speaker was to be Dr. John F. Kenney of Pawtucket, R. I., past president of the Rhode Island Medical Society. However, the night previous to the meeting, Dr. Kenney died. His manuscript which had been submitted to the Secretary of the Association the previous day was read by each member, and it was voted to present the manuscript to the Editor of the Rhode Island Medical Journal with the request that it be printed in that publication.

The meeting adjourned at 10:45 P. M.

Respectfully submitted,

ARCADIE GIURA, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kent County Medical Society was held on Tuesday, March 21 at the I. M. Gan Building, Post Road, Apponaug.

The meeting was called to order at 9:25 P. M. by Dr. Joseph C. Kent.

Application for membership into the Society was received from Dr. Ansalen Schurgast of 10 Herbert Street, Warwick, R. I. Application was signed by Dr. Charles Phillips and Dr. Fenwick Taggart. This application was referred to the Board of Censors for further action.

A letter was received from the State Health Department in regards to plans for a mass chest survey in the area of West Warwick. Motion was made by Dr. Wittig and seconded by Dr. Taggart that the Society go on record of approving this chest survey.

Following the regular business meeting the Director of the second fund raising campaign for the Kent County Memorial Hospital was introduced by the President. He stressed the need for workers in the campaign and emphasized the importance of having a complete coverage of residents of the entire County. He also told that there were approximately 2700 prospects that were not solicited during the first campaign.

An appeal was made to the members of the Society for individual contributions and not collective pledges.

Following this discussion it was decided to call a special meeting of the members on Tuesday, March 28th at 9:00 P. M. in order to take final action by the members for this second fund raising appeal.

Meeting adjourned at 10:35 P. M.

Respectfully submitted,

E. T. HACKMAN, M.D., *Secretary*

continued on page 258

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PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held on Monday, April 3, 1950, at the Medical Library of the Rhode Island Medical Society. The meeting was called to order at 8:35 p. m. by Dr. Frank W. Dimmitt, Vice President, who presided in the absence of Dr. U. E. Zambarano, President.

With the approval of the members present the reading of the minutes of the previous meeting was omitted.

The secretary reported two communications. One was an invitation to the membership to attend the International Congress of Obstetrics and Gynecology, to be held in New York May 14-19. The other was from Dr. William H. Magill reporting office equipment that he has available for sale.

Dr. Dimmitt announced the appointment of the Association's committees to prepare tributes of the Association to deceased members:

To prepare the Association's tribute to the late Dr. Pearl Williams:

Dr. Herbert G. Partridge and Dr. Elihu S. Wing.

To prepare the Association's tribute to the late Dr. Alan E. O'Donnell:

Dr. Francis V. Corrigan and Dr. Frank A. Merlino.

To prepare the Association's tribute to the late Dr. Jacob S. Kelley.

Dr. Herbert H. Armington and Dr. William H. Foley.

Dr. Dimmitt called upon Dr. Stanley S. Sprague, Chairman of the Committee on Industrial Health of the Rhode Island Medical Society, to discuss the Rehabilitation Seminar to be held on April 12. Dr. Sprague briefly reported on the plans for the meeting and urged the members of the Providence Medical Association to attend.

The first guest speaker of the evening was Milos J. Lota, M.D., Haffenreffer Fellow in Medical Science, Brown University and R. I. Hospital; Formerly Professor of Physical Medicine at Charles University, Prague, Czechoslovakia, who spoke on "SOME NEW ASPECTS IN RADIATION THERAPY WITH SPECIAL CONSIDERATIONS ON THE PRACTICAL USE OF INFRARED AND ULTRAVIOLET IN CLINICAL MEDICINE."

Dr. Lota stated that psysiotherapy is one of the oldest types of medicine since it was used years ago. All electromagnetic waves travel at the same speed, 186,000 miles per second. Each kind of radiation can be determined by its wave lengths and frequency. Short waves vibrate at greater frequency. The standard unit for measuring wave lengths is the Armstrong unit. An Armstrong unit equals 0.1 millimicron (one micron equals 1/1000 of a millimeter).

Light projected thru a glass prism is dispersed in-

to a spectrum. Ultraviolet is at one end and infra red at the other. Only a small part of the electromagnetic spectrum is visible. We have in their order, radio waves (short waves) used in diathermy, infra red, solar rays, visible rays, ultra violet x-rays, gamma rays, and cosmic rays. The cosmic rays are the shortest.

Light consists of a bunch of photons. The smallest unit of matter is the atom,—the smallest unit of radiant energy is the photon, the size of which is proportionate to the frequency of the unit. The photon has a speed of 300,000 kilometers per second. This speed is maintained until it is stopped by a liquid or solid body. This body then contains activated molecules. An activated molecule causes more vibration of the molecule. Activated molecules exist only a short time, only a millionth of a second, when it passes to photosynthesis or degradation to heat. Rays penetrate all substances to some extent. Various layers of skin are transparent to various wave lengths. The intensity of the radiation varies with the square of the distance from the source. The intensity also varies with the cosine of the angle to the patient's body. Therefore always place the lamp so that the rays reach the patient at right angles for the maximum intensity.

Radiation penetrates the human skin differently according to the wave length. Visible rays have a higher absorption in the corium, ultra violet rays a large absorption in the malpighian layer.

Light sensitivity of skin is highest in spring and autumn. The sun is the most important source of infra red radiation. The incandescent lamp produces 95 per cent infra red rays. Infra red rays produce heat and erythema by stimulation of vasomotor mechanism. Deep erythema persists ten minutes to several hours after exposure.

The clinical uses of infra red rays produce muscle relaxation and relief of pain. Used in subacute to chronic inflammatory conditions, contusions, muscle sprains, synovitis, tenosynovitis, fractures, and arthritis. Infra red hyperemia makes the skin more susceptible to ultraviolet radiation causing a deeper penetration.

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(3) Apply with caution over old scars
(4) Do not use in fibrile cases

The second speaker was John L. Fromer, M.D., Member of the Staff, Allergy and Dermatology Service, the Lahey Clinic, Boston, who spoke on "MANAGEMENT OF COMMON SKIN DISEASES."

Dr. Fromer presented a classification of the eczema group of skin disorders. He listed the following groups:—seborrheic, hemostatic, (such as occur in varicose ulcer cases), intertrigo group,

continued on next page

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 259

lichen simplex, and the dermatophytic group. In general the group is quite polymorphous.

Atopic dermatitis includes bakers and milkman's eczema. This is treated with diet, allergically denatured foods, dust proof environment, and topical treatment.

In infantile eczema, 41 per cent react to food, and 59 per cent to food and inhalants.

Contact dermatitis sensitization follows the law of serum sickness. You have contact, an incubation period, and re-contact with onset of symptoms. The same holds true with any industrial exposure.

He treats eczema with wet dressings and bland lotions. As it subsides he adds a bland cream. For general measures use a restricted diet, bed rest, antihistamine sedatives, I. V. procaine, and liver extract. In persistent acne he uses antogenous vaccines, staphloccus, toxoid, liver extract, vitamin A, and in older males stilbestrol. He advises against using local penicillin or sulfa drugs. Sycosis barbae he treats with penicillin generally and local application of ammoniated mercury. A saturated solution of sodium thiosulfate is used for taenia versicolor which is due to a fungus infection. He uses testosterone therapy for lupus erythematosis.

Since the skin normally has a p.h. of 4-5, fatty acids are very useful in prophylaxis against ringworm infection, e.g. caprilic acid, such as is found in desenex.

Attendance was 73. The Meeting adjourned at 10:40 p. m. Collation was served.

Respectfully submitted,
DANIEL V. TROPPOLI, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held on April 20, 1950, in the Nurses dining room of Memorial Hospital. This was a dinner meeting and fifteen members attended.

The meeting was called to order by the President, Dr. James P. Healey at 7:15 P. M. The minutes of the annual meeting were read and accepted.

The secretary reported on a letter from Dr. John G. Walsh announcing the meeting of the International and Fourth American Congress on Obstetrics and Gynecology, in New York, May 14-19, 1950.

A bulletin from Whitaker and Baxter including addresses delivered at the February Conference of the National Education Campaign was noted and its legal memoranda regarding participation in election campaigns.

There was also a letter from Dr. William L. Leet requesting one of our group to be a member of the

continued on page 267



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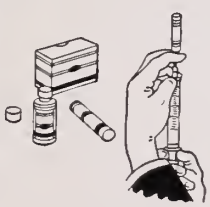
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COMPONENT SOCIETIES BY MEDICAL DISTRICTS — 1950

SOCIETY	DELEGATES	COUNCILLOR	OFFICERS	MEETING
Kent County Medical Society	Rocco Abbate Peter Erinakes	Arthur Hardy	*President*, Joseph Kent *Vice Pres.*, Jean M. Maynard *Secretary*, Edmund Hackman *Treasurer*, John Mack	3rd or 4th Tuesday of each month
Newport County Medical Society	Frank Logler Donald B. Fletcher	Samuel Adelson	*President*, Henry W. Brownell *1st Vice Pres.*, Robert L. Bestoso *2nd Vice Pres.*, John M. Malone *Secretary*, Osmond Grimes *Treasurer*, Norbert U. Zielinski	4th Tuesday of every other month, starting September
Pawtucket Medical Association	Earl Mara Edward H. Trainor Henry Hanley Robert T. Henry Henry Turner	Charles L. Farrell	*President*, James P. Healey *Vice Pres.*, Kieran Hennessey *Secretary*, Hrad Zolmian *Treasurer*, Laurence A. Senseman	3rd Thursday of every month
Washington County Medical Society	Louis Morrone Samuel Nathans	John Paul Jones	*President*, Clifford Hathaway *1st Vice Pres.*, Thomas Nestor *2nd Vice Pres.*, Julianna R. Tatum *Secretary*, Samuel S. Farago *Treasurer*, Samuel S. Farago	2nd Wednesday of every 3 months, starting October
Bristol County Medical Association	John A. Mellone	Paul C. Bruno	*President*, Ralph J. Petrucci *Vice Pres.*, Hubert Holdsworth *Secretary*, Arcadie Giura *Treasurer*, Antonio DiAngelo	3rd Tuesday of each month
Woonsocket Medical Society	George Keegan Joseph McKenna	T. J. Lalor	*President*, Leo Dugas *Vice Pres.*, Alfred King *Secretary*, Emil Kaskiw *Treasurer*, Paul Boucher	No fixed date
Providence Medical Association	Robert Baldridge J. Murray Beardsley Peter Pineo Chase E. Victor Conrad Frank B. Cutts William P. Davis Donald DeNyse John Dillon	Albert H. Jackvony William J. H. Fischer David Freedman Herman Grossman Peter Harrington William Horan Russell Hunt	*President*, Ubaldo E. Zambarano *Vice Pres.*, Frank W. Dimmitt *Secretary*, Daniel V. Troppoli *Treasurer*, J. Murray Beardsley Louis I. Kramer Herman A. Lawson Edward McLaughlin Robert Murphy John C. Myrick Joseph C. O'Connell	1st Monday of every month; Oct.—May inclusive Michael O'Connor Edwin O'Reilly Alfred Potter Louis Sage Daniel Troppoli George Waterman

SOCIETY	OFFICERS	ANNUAL MEETING	CHAIRMAN, STANDING COMMITTEES	
Rhode Island Medical Society 1950-1951	*President*, Charles J. Ashworth *Vice Pres.*, Robert T. Henry *Pres. Elect*, Herman A. Lawson *Secretary*, Morgan Cutts *Treasurer*, Earl F. Kelly *Ass't. Treas.*, John Dillon	May 9 & 10, 1951 at Rhode Island Medical Society Library, 106 Francis Street Providence 3, R. I.	Joseph C. O'Connell Charles L. Farrell James H. Fagan Marshall Fulton Nathan Chaset Stanley Sprague Herbert G. Partridge John E. Donley Edgar S. Potter & Albert H. Jackvony	Scientific Work and Annual Meeting Public Policy and Relations Public Laws Postgraduate Education Medical Economics Industrial Health Library Publications Auditors



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THE CITY OF NEWPORT

Resolution of the Representative Council

No. 65-50

Resolved:

WHEREAS, Michael Henry Sullivan, M.D., a native son of Newport, was graduated from Harvard Medical School fifty years ago and after serving an internship at the Carney Hospital, Boston, Massachusetts, established himself in the practice of medicine in this city, and

WHEREAS, he has served the citizens of Newport faithfully and loyally, irrespective of color, race or creed, rich and poor alike, since 1901, and

WHEREAS, he has served the City of Newport as a member of the Board of Health for Thirty-four years and is now the President of that Board, and

WHEREAS, he has served his country at great sacrifice to his time and energy as Chief Examiner for the Newport Selective Service Boards in World War I and World War II, and

WHEREAS, he has been an inspiration to many younger physicians, being advisor, teacher and friend, sharing with them his skill and ability in the art of science and healing, and

WHEREAS, his professional colleagues have shown their faith and confidence in him by electing him President of the Newport County Medical Society and the Rhode Island Medical Society, and

WHEREAS, he has endeared himself to the hearts of all of the people of Newport and has merited their esteem and affection, so therefore, be it

RESOLVED, that the City of Newport takes cognizance of the exceptional and outstanding service he has rendered the citizens and hereby pays tribute to one of its most illustrious sons, and be it further

RESOLVED, that copies of this Resolution be sent to the Newport County Medical Society and to the Rhode Island Medical Society and that a copy suitably engrossed and sealed with the seal of the City be presented to Dr. Michael H. Sullivan.

IN REPRESENTATIVE COUNCIL
READ AND PASSED
APRIL 4, 1950
A TRUE COPY ATTEST:
(S) Henry S. Wheeler, City Clerk

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APPOINTED COMMITTEES . . . 1950-1951

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Edward S. Cameron, M.D., Providence
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Emanuel Benjamin, M.D., Providence
William M. Muncy, M.D., Providence
James P. Deery, M.D., Providence

PAWTUCKET MEDICAL ASSOCIATION

concluded from page 260

Nutrition Committee of the R. I. Medical Society to be organized by him.

A communication from the Committee on Public Laws of the R. I. Medical Society was reported on. It reviewed proposed laws before the R. I. General Assembly to which opposition has been voiced by the committee. Emphasis is placed on House 835 which would lower basic science requirements, and Senate 301 which would make admissible as evidence in malpractice actions statements of fact or opinion from treatises, periodicals, books, or pamphlets.

Motion was made and passed that a letter be sent to the Committee on Public Laws informing it of our resolution endorsing its action.

The meeting then retired to the Nurses Auditorium to hear Dr. Charles E. Millard, President, R. I. Chapter, American Academy of General Practice, speak on, "Problems of the General Practitioner and Their Solution." Complaints of general practitioners were presented and also recommendations as to specialist-general practitioner relationships and staff privileges. Raising the standards of general practice and the physician-patient relationship with restoration of the general practitioner to his old place of importance was urged.

Application forms for the American Academy of General Practice were distributed. The meeting adjourned at 9:00 P. M.

Respectfully submitted,
HRAD ZOLMIAN, M.D., *Secretary*

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MEDICAL BUREAU
of the Providence Medical Association

BOOK REVIEWS

HANDBOOK OF MEDICAL MANAGEMENT by Milton Chatton, Sheldon Margen and Henry B. Brainerd. University Medical Publishers, Palo Alto, California, 1949, $3.00.

This pocket size *Handbook of Medical Management* is designed primarily as a ready reference for the medical student and practitioner, and endeavors to provide essentials of modern methods of treatment to be used after the establishment of a diagnosis. It consists of 453 paper bound pages divided into twenty chapters and appendix plus an excellent index. The contents are arranged in outline form under the various chapter headings. The nomenclature follows that of the *Standard Nomenclature of Disease and of Operations* of the American Medical Association and includes the use of the code numbers. The names of chemicals and medicines mentioned are usually accepted drugs of the U.S.P., N.F., and N.N.R. Where proprietary preparations have been found to be in general use or of especial importance their use has been mentioned. Dosages are expressed in both the metric and apothecary systems.

The first three chapters are concerned with the general aspects of treatment and with dietetics. The activity status of the patient is considered for various general groups of diseases and recommendations for the degree of bed rest and for the use of the various bed positions, with simple sketches of the latter are made. The notes on patient environment and home management should be useful in discussing these subjects with those responsible for the care of the patient. A review of the clinical observations to be made by the physician is offered. The chapter of symptomatic treatment considers pyrexia, pain, shock, asthenia, anorexia, insomnia, weight and psychotherapy, with particular emphasis on the treatment of shock and the alleviation of pain. Caloric tables, sample diets, and types of diets followed by a brief review of the individual vitamins and fluid balance completes the general discussion of therapy.

Throughout the book frequent use is made of tables which provide a quick comparison of diagnostic features, dosage schedules, or comparative treatments as the case may be. Thirteen pages of the chapter on dermatology are devoted to tables giving types of skin disease, the methods of treatments of choice at various stages of the disease, strengths and forms of medicaments, and special prescriptions; in themselves, an excellent outline of dermatological therapy. Other tables, while not as complete nor elaborate, are well constructed and usable.

The remaining chapters consider various diseases on a symptomatic or etiological basis. Emphasis is on treatment, though, in the more complicated conditions where diagnosis may be difficult attention is given to the more salient points. Thus, the differential diagnosis of peripheral vascular diseases, the leukemias, liver disease, arthritis, cardiac disease and some others are considered at some length. While more space is devoted to the commoner and more complicated diseases and treatments the subject material is surprisingly complete. Where completeness is lacking there are sufficient notes to prompt the physician to look to the standard texts for detailed information and to guide him to the most helpful sections quickly, and to serve as a guide for the immediate care of the patient.

It is the intention of the authors and the publisher to print an annual edition to maintain the usefulness of the work. The book can be recommended to the practitioner as one to be carried with him as an outline of treatment, as an aid in bringing prompt use of therapeutic methods and medicines to the benefit of the patient, and as a reminder of available techniques and drugs to the physician.

A. LLOYD LAGERQUIST, M.D.

HUMAN GROWTH by Lester F. Beck. Harcourt, Brace and Company, N. Y. 1949. $2.00.

HUMAN GROWTH contains the same subject matter and pictures as the much discussed film of the same name. It gives the biological facts of human conception, fetal growth, birth, and development of the body and sex glands though adolescence to adult-hood.

The book is divided into four chapters. Following each chapter are questions and answers — questions which any normal, inquisitive child usually asks.

Chapter I describes the steps in the growth of a baby, and compares the growth of the boy and girl. Various glands control growth and other body functions.

continued on page 271

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BOOK REVIEWS
continued from page 268

Chapter II describes and gives diagrammatic pictures of the sex glands and the male and female reproductive cells — sperm and ova.

Chapter III, called "Preview to Parenthood", gives the process of fertilization and division of the fertilized ovum into many cells — and finally a baby.

Chapter IV is entitled "The Miracle of Birth." The embryo or fetus is described at various stages of growth. Words and diagrams portray how a baby is born.

This small, compact book is very good for acquainting young people with actual biologic facts but deals not at all (no doubt intentionally) with problems which may arise in discussions (such as petting, masturbation, venereal diseases, etc.).

Highly recommended for teachers, parents and growing boys and girls.

MERLE MOSIER POTTER, M.D.

CLINICAL PATHOLOGY—APPLICATION AND INTERPRETATION. By Benjamin B. Wells, M.D., Ph.D., Professor of Medicine, University of Arkansas School of Medicine, Little Rock, Arkansas. W. B. Saunders Company, 1950.

There are numerous laboratory books dealing in great detail with the technical procedures of the various tests and in varying degree with their interpretation. These, for the most part, are of especial interest for the clinical pathologist, medical student, or for the unusually studious medical man. What has been lacking has been a book which is free of frills and furnishes the reader with sufficient background of the why and wherefore of certain laboratory tests indicated in a suspected disease process and a brief interpretation of the significance of the results. Wells' book, "Clinical Pathology — Application and Interpretation," does this very nicely.

The author has arranged the material in the book in the manner in which a physician may practically use it. "Beginning with a clinical situation, the applicable laboratory procedures are selected and their contributions to the problem are discussed with just enough theory and methodology to convey proper meaning and purpose." The book, arranged in nine chapters, deals with the application of clinical pathologic methods to infectious diseases, diseases of gastro-intestinal system, diseases of the respiratory system, diseases of the kidney and urinary tract, diseases of the blood, diseases of the cardiovascular system and metabolic and endocrine disorders.

The author has personalized the interpretation and evaluation of various laboratory procedures so that the book is easily readable and informative.

Although one might criticize the lack of greater detail in discussion of acid-base balance, this may properly belong to a monograph on the subject or one of the larger tomes on laboratory interpretations.

A quotation from the author's introductory considerations gives an insight to the author's approach to laboratory medicine: "We must constantly be aware of the fact that laboratory results are only one aspect of the total clinical observation. Seldom, if ever, are these tests subject to valid interpretation except as they pertain to all other manifestations which characterize the normal or abnormal state of the patient. Insufficient or improper use of the laboratory is most often an evidence of ignorance; excessive reliance on laboratory results is proof of inexperience."

The reviewer is favorably impressed with the book and would recommend it to all practicing physicians, interns, and medical students.

HERBERT FANGER, M.D.

SEXUAL DEVIATIONS, A Psychodynamic Approach by Louis S. London, M.D., and Frank S. Caprio, M.D. The Linacre Press, Inc., Washington 6, D. C., 1950. $10.00

There appears to be recently an increasing interest, or better, an accentuation of our interest, in matters pertaining to sex. Some of the latest publications have approached this ever-intriguing question from social, zoological, medical, and anthropological points of view. Our daily and popular press always carries at least one article pertaining to sex education, sex morals, sex crimes, etc.

It is timely, therefore, that this new book undertakes to describe, analyze, and offer a psychological explanation of the most puzzling aspect of sex, namely, the perversion of sex impulse, or sexual deviations. Both of the authors of this book are practicing psychoanalysts. The material comprising the greatest part of this book (Part II, over 600 pages) consists of case histories of patients treated by the authors in their private practice of psychoanalysis. Hence the "psychodynamic approach" or a method of psychiatric interpretation based predominantly on ideas and theories of Sigmund Freud and those of Stekel is thus illustrated.

Part I opens with a foreword by Dr. Nolan D. C. Lewis and a brief historical survey of the literature on the subject. A brief chapter on the development of the sexual impulses in the child follows. A short chapter on the theoretical considerations on deviation of sexual impulses in the adult concludes this part. These two chapters are intended to supply the basis and the theoretical foundation for the understanding of the case histories that follow. The case histories are in a sense real multidimensional portraits of the deviates and present an amazing collection of appropriate psycho-

continued on inside back cover

VITAL STATISTICS — 1949

DEPARTMENT OF HEALTH, CITY OF PROVIDENCE

I hereby present the preliminary report of Vital Statistics and Health Department Activities for the year 1949.

The 3058 deaths was the smallest number of deaths listed in the City of Providence since the year 1898 when 2928 deaths were reported. In this City the next smallest number was 3068 in 1934. There has been a slight increase in the deaths from Heart Disease. It is interesting to note that deaths from Nephritis and Cerebral Hemorrhage have decreased. It is also gratifying to note that deaths from Cancer have decreased. Pneumonia deaths are showing a continuous drop and this is the smallest number of deaths recorded in any one year since the Civil War.

Our Infant Mortality rate is the lowest ever recorded as is our crude death rate. The Birth rate 38.19 has been exceeded only in the years 1946-47-48.

It is interesting to note that our Communicable Disease record has also been very satisfactory with the lowest number of deaths from Pulmonary Tuberculosis reported in a single year.

While 1949 was a Measles year with 3254 cases reported, there was no death of a Providence resident attributed to this disease. Only 2 cases of Diphtheria were reported during the year.

Our Immunization Program has been proceeding very satisfactorily. Although the number immunized at the City Clinics are small, most every child in the City has been properly vaccinated and immunized, the majority by their own family physician.

On the whole the Health situation in the City is very satisfactory.

JOSEPH SMITH, M.D.
Superintendent of Health

Preliminary Report of Health Department Statistics — 1949

	1949	1948	1947
VITAL STATISTICS			
Deaths all	3058	3194	3270
Deaths under 1	227	235	281
Deaths over 70	1178	1274	1246
Births	10160	10341	11190
Marriages	2554	3257	3525
Infant Mortality	21.35	22.62	25.11
Death Rate	11.50	12.00	12.29
Birth Rate	38.19	38.87	42.06
PRINCIPAL CAUSES			
1. Heart Disease	1184	1167	1143
2. Cancer	483	491	486
3. Pneumonia	71	85	106
4. Nephritis	134	143	179
5. Cerebral Hemorrhage	154	211	201
6. Auto Accidents	25	30	40
MILK DEPARTMENT			
No. Samples Tested	15628	17016	17686
No. Licenses Issued	1584	1513	1464
PHYSICIANS			
No. Visits to Sick Poor	436	302	309

	1949	1948	1947
DIPHTHERIA IMMUNIZATION			
No. Schick Tests	8732	7557	7879
No. Alum Toxoid Treat.	109	3975	4538
No. Tri-Immunol Treat.	736		
No. Diph. Tox. Prot. Prec.	3354		
SMALLPOX IMMUNIZATION			
No. Vaccinated	1442	1606	1684
INSPECTORS			
Food Inspector:			
Inspections	10456	7897	7190
Licenses Renewed	306	3921	1940
New Licenses	1300	258	215
Transfers	137	152	177
Licenses Withdrawn	2	1	2
Liquor Lic. Transfers	3		
Licenses Not Approved	9	11	17
Sunday Sales Trans.	8		
Lunch Cart Licenses	3	3	3
Sunday Sales Renewed	378		
Liquor Lic. Renewed	530		
Sanitary Division:			
No. of Visits	8602	8289	6795
Animal Bite Visits	2166	2018	1810
Kennel Lic. Approved	28	29	39
Garbage Lic. Approved	30	18	19
NURSING VISITS			
Communicable Diseases	5114	2772	677
Parochial Schools	5571	4272	3890
Tuberculosis-Home	8970	9991	902

COMMUNICABLE DISEASES	CASES				*DEATHS*			
	1949		1948		1949		1948	
	Res.	Non Res.	Res.	Non Res.	Res.	Non Res.	Res.	Non Res.
Diphtheria	2	1	3	2	0	0	1	0
Scarlet Fever	134	61	194	41	0	0	0	1
Measles	3254	60	244	17	0	1	0	1
Whooping Cough	200	11	160	15	2	0	0	0
Pulmonary Tuberculosis	204		244		24	13	42	10
Septic Sore Throat	1	0	0	0	0	0	1	0
Strep Sore Throat	12	0	9	1	0	0	0	0
Gastro Enteritis	39	9	34	14	5	2	6	3
Bacillary Dysentery	6	0	7	2	0	0	1	0
Poliomyelitis	50	120	1	7	0	0	0	0
Epidemic Meningitis	6	4	4	8	3	0	0	1
Typhoid Fever	0	2	5	0	0	0	0	0
Paratyphoid Fever	3	0	4	2	0	0	0	0

*Includes Non-Residents

BOOK REVIEWS

concluded from page 271

pathological material. The case histories include the family history and setting, psychosexual development, traumatic incidents, various indulgencies and deviations of the patient. These are concluded by dream analyses, interpretation of psychodynamics, and a so-called epilogue, usually indicating that patients have been relieved of their deviations by the appropriate treatment, i.e., psychoanalysis. Part III of the book concerns itself with: psychosomatic ailments associated with sexual pathology, an interesting chapter on medicolegal management of sex offenders, a glossary of terms, and a bibliography.

I feel that the plan of this book is an ambitious one, but in executing it the authors were not able to avoid many of the pitfalls inherent in such an undertaking. There is no doubt that a sound understanding of the sexual deviates and their mental processes is imperative for doctors, lawyers, educators, and social workers because of the nature of their work. However, for those who have little or no psychiatric experience, this book may be rather confusing. The chapters on the sexual impulses of the child and deviations in the adult are certainly not a sufficient preparation for the reading public not versed in psychoanalytic theory or philosophy. There is also the danger that the use of psychoanalytic terminology will be accepted by many and used with the ease and facility of a jargon without the understanding of the real meaning and value of the terms. On the other hand, to a number of experienced therapists, well grounded in psychodynamic principles, this book might be of limited interest only. It is also my feeling that the medical students and beginners in psychiatry who will read this book before they have had a sufficient amount of actual experience in dealing with deviates, will obtain easy formula-like answers and this may impair their personal appreciation of actual psychopathology in individual cases. Some of the material in the case histories is repetitious and poorly organized from a chronological viewpoint. There is also a certain looseness and uneveness of style, as for example:

"Sadism is turned into masochism as the result of consciousness of guilt. Stekel has shown the relationship of sadism to homosexuality, whether it be male or female. In masochism, the sadism is directed against the person himself. This is the result of guilt through moral and religious influences of childhood." (Page 245). And again,

"Epilogue: One year after the analysis ceased, the patient reported that she met a Major who said that she was the most passionate woman he had ever met. This was fourteen years ago. Nothing has been heard of her since." (Page 245)

I agree with the authors that this work is rather "a beginning — not an ending". This book contains a vast amount of interesting material to be carefully appraised and digested. The work of the authors is that of pioneers and as such should be appreciated.

SIDNEY S. GOLDSTEIN, M.D.

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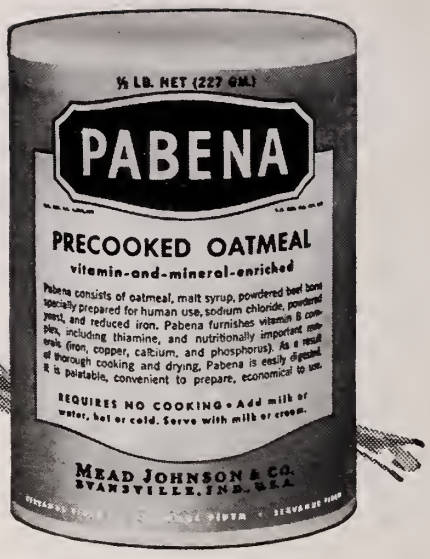
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(See Page 328)

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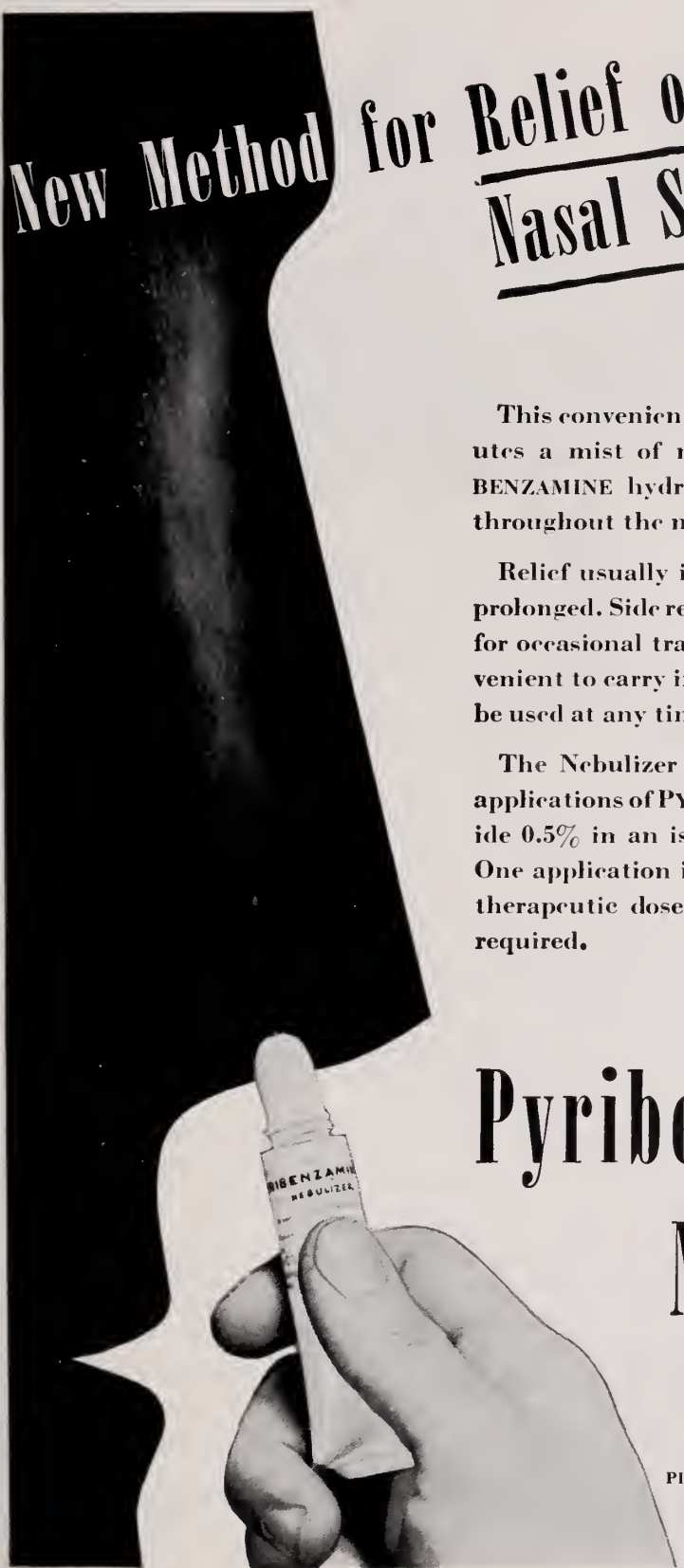
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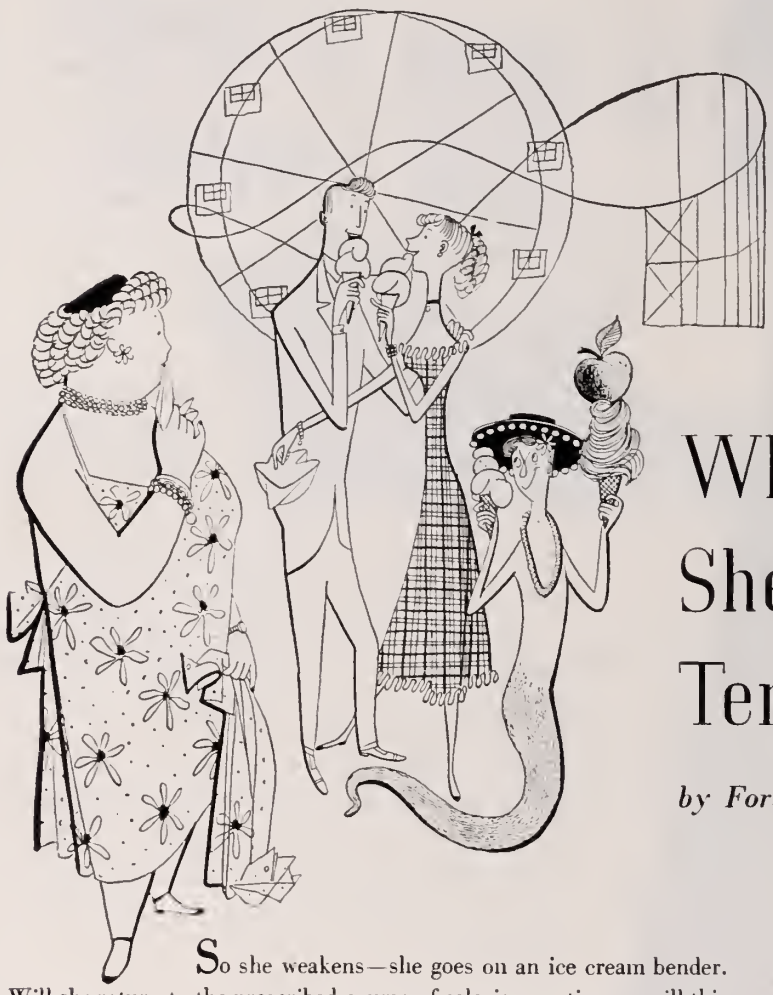
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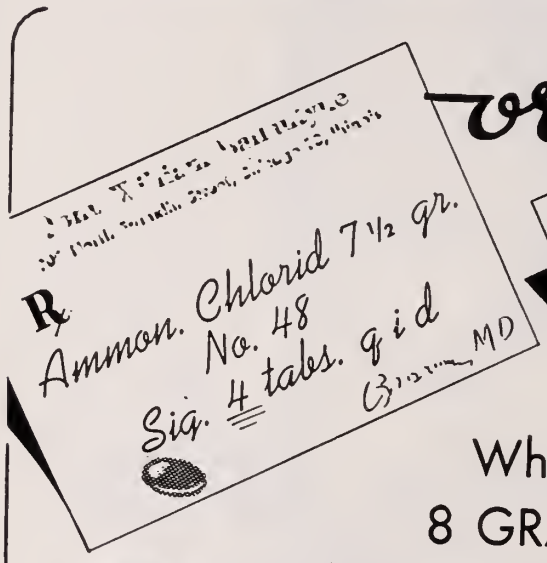
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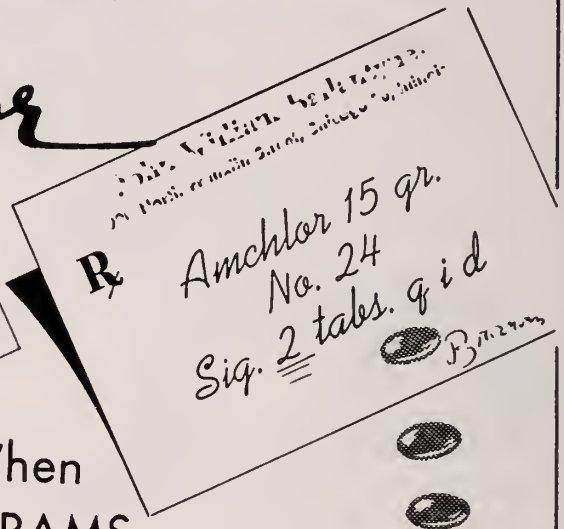
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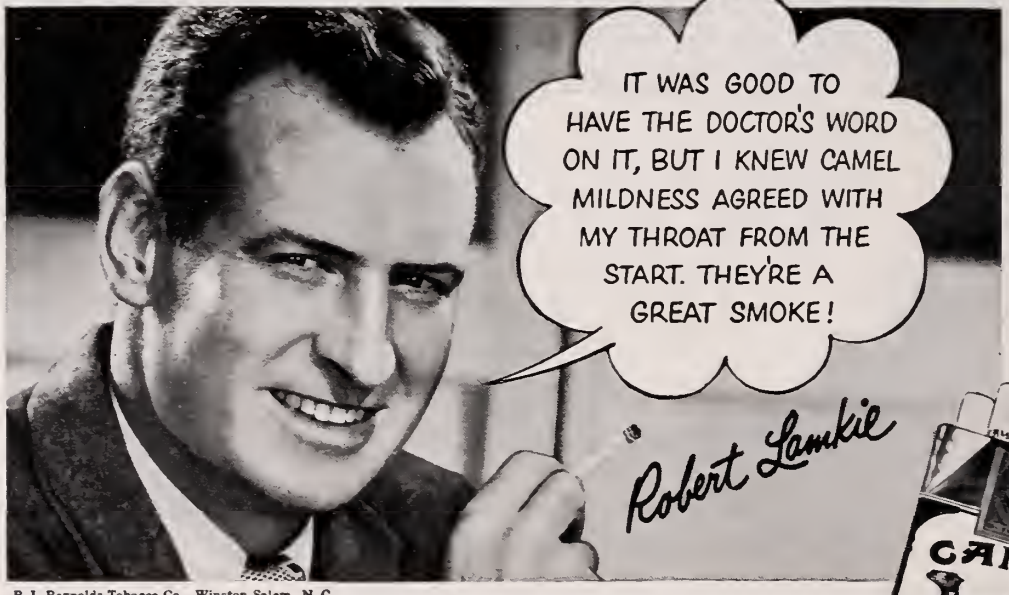
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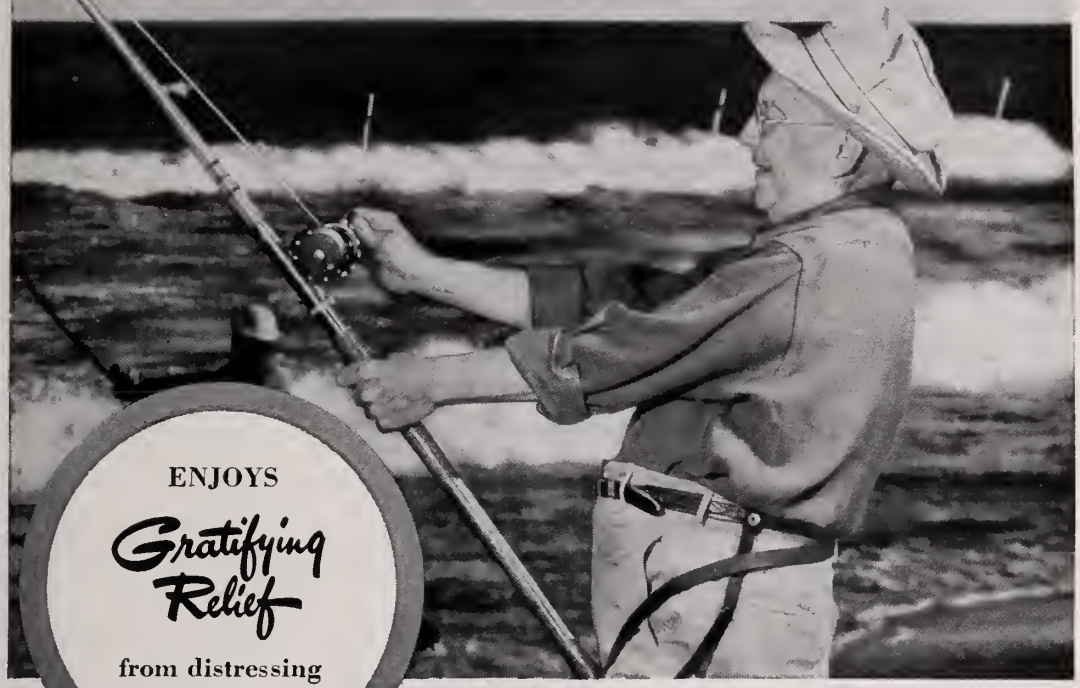
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VITAMIN B_{12} AND FOLIC ACID, given together by mouth, have a pronounced synergistic action. A non-therapeutic amount of folic acid has been found to promote the utilization of vitamin B_{12} in oral doses formerly believed to be ineffective.

HOW DOES IT ACT?

Vitamin B_{12} for extrinsic factor-like activity

Given by mouth, vitamin B_{12} acts like the extrinsic factor of food. The effective oral dose is some 30 to 60 or more times greater than the effective parenteral dose.

Folic acid for intrinsic factor-like activity

Meyer and associates[1] assert that, in vitamin B_{12} and folic acid therapy, "folic acid acts like 'intrinsic factor'" in that it promotes utilization of vitamin B_{12}. The role of folic acid "on the release, absorption or synthesis of vitamin B_{12} in the intestinal tract" is open to speculation, according to Cartwright, Wintrobe and others.[2] Folic acid, Best and Taylor[3] state, may possibly "act to stimulate the production of the intrinsic factor or be the intrinsic factor itself."

B_{12} and folic acid are essential

Luhby and Wheeler[4] suggest:

1. If a folic acid deficiency is profound, even large doses of vitamin B_{12} are hematologically inert.
2. If a severe vitamin B_{12} deficiency exists, large doses of folic acid should be hematologically inactive.

They advance the following possible equation:

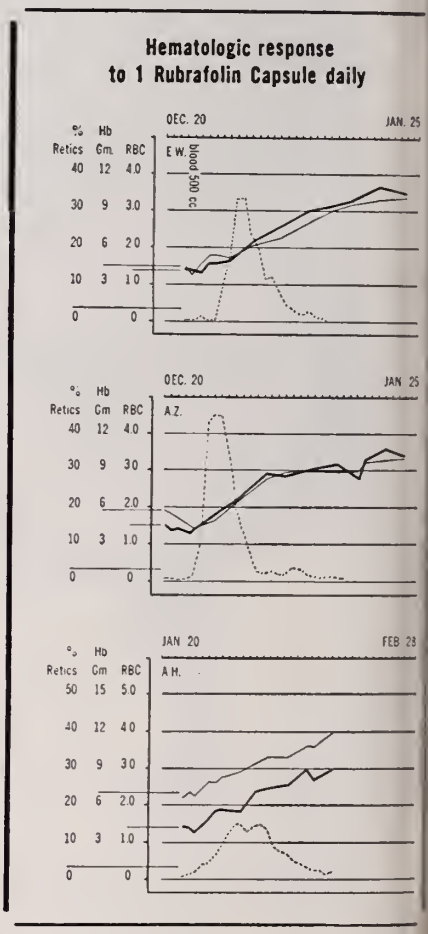
(Folic acid) x (Vitamin B_{12}) ——→ (E.M.F)

WHAT ARE THE RESULTS OF THERAPY?

With vitamin B_{12} and folic acid, given orally, hematologic response frequently parallels that of parenteral vitamin B_{12} therapy. Ordinarily, clinical remission is both prompt and dramatic. Furthermore, in patients so far studied, oral vitamin B_{12} and folic acid apparently protects against and reverses manifestations of combined system disease.

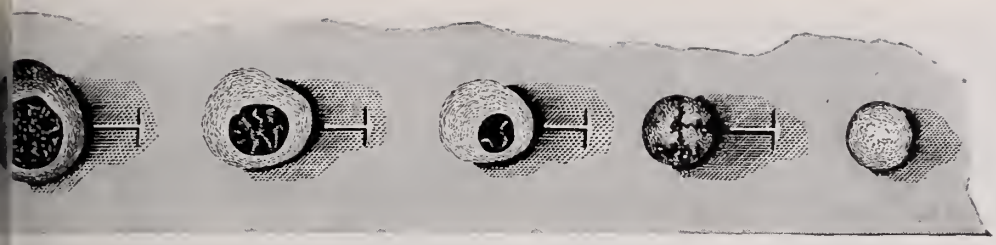
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Macrocytic anemias ordinarily respond well to vitamin B_{12} therapy. These include pernicious anemia without neurologic involvement, pernicious anemia with combined system disease, nutritional macrocytic anemia, tropical sprue, non-tropical sprue. (Pernicious anemia of pregnancy responds best to folic acid therapy.)



d Vitamin B_{12} Alone (Parenteral and Oral)

tamin B_{12} alone—parenteral administration

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tamin B_{12} alone—oral administration

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BRAMIN* Capsules micrograms of vita- B_{12} per Capsule).	6 to 12 Capsules daily.	To be adjusted to patient's needs.		Bottles of 100 Capsules.
BRAMIN or 30 microgram puls; 5 and 10cc. ls—30 micrograms cc.	15 to 30 micrograms once or twice a week.	15 micrograms every 2 weeks or 30 micrograms once a month.	Larger therapeutic doses must be used in the presence of moderate to severe neurologic involvement.	1 cc. ampuls, 15 or 30 micrograms of vitamin B_{12} per ampul. Boxes of 5. 5 and 10cc. vials, 30 micrograms of vitamin B_{12} per cc. also available: Solution Rubramin Crystalline (Squibb Crystalline Vitamin B_{12} Solution) in 1 cc. ampuls, containing 15 micrograms of crystalline vitamin B_{12}.

liography: 1. Meyer and associates: A. J. ., Path. (in press). 2. Cartwright, Wintrobe associates: Blood 4:301, 1949. 3. Best and lor: The Physiological Basis of Medical Prac- , ed. 5, Baltimore, Williams & Wilkins, 1950, 7. 4. Lubby, A. L.; and Wheeler, W. E.: The lth Center Jl. (Ohio State Univ.) 3:1, 1949.

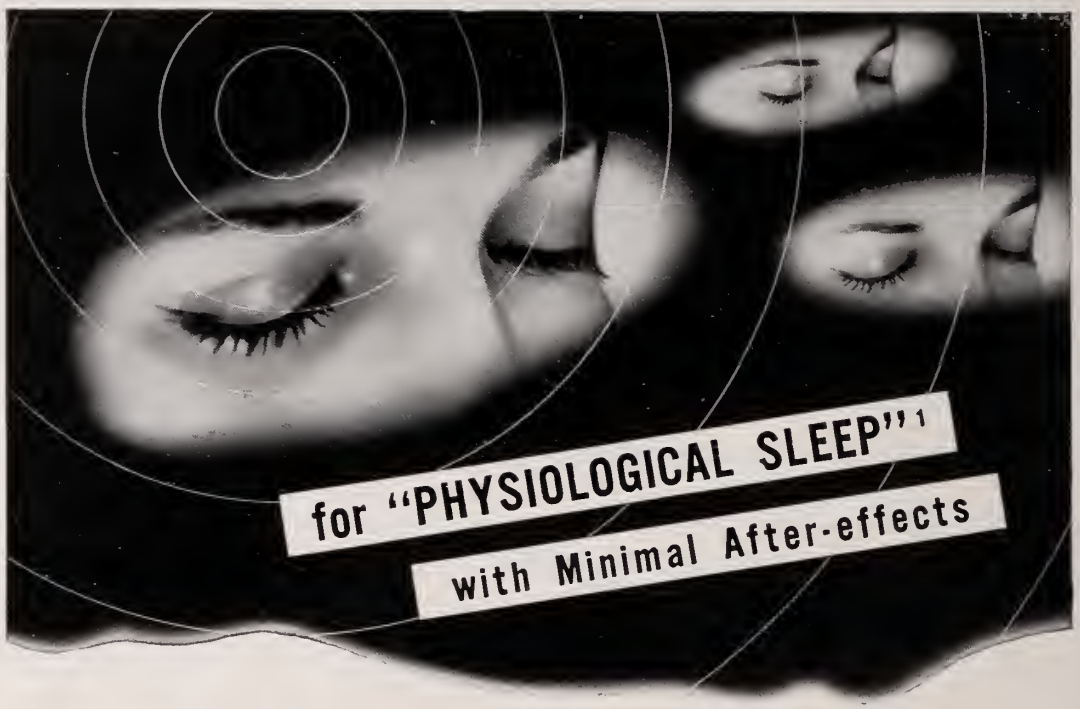
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[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics, MacMillan, 1944, pp. 177-8.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXIII JUNE, 1950 NO. 6

ELABORATION IN MEDICINE*

PETER PINEO CHASE, M.D.

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THERE is a well-known story of Calvin Coolidge going to church and on returning home reporting that the minister talked about sin. On Mrs. Coolidge asking details regarding the argument her husband replied that the preacher was *agin* it. It is easy to hold the sympathy of your audience when you take such a safe ground. I have set myself a more awkward task. I am talking against the use of good things.

In doing this, I am following the thought of a certain Bishop of London who said, "Few do more harm than those who go about doing good." We all ought to know that too much of a good thing is a bad thing. That, to my mind, is a serious mistake in modern medicine.

To simplify the argument, I am going to emphasize one aspect, the financial. I might as well admit at once that I am a reactionary. I do not believe that bureaucratic control of medicine will be good and I rather think that at present most of you feel that way. The principal plea for it seems to be that the increasing cost of medicine is more than we can handle and we will have to let the government pay the bills. I think you are rapidly forcing this result by your extravagant ways, many of which could reasonably be curtailed. Let us consider a few details.

A constant stream of literature flows into our offices from the big companies supplying the tools of our trade. I suspect that I read more than the average doctor but I must admit that the major part of this is never read by me. Yet much of it is of the highest quality, illustrated by good artists and written, undoubtedly, by able men. The cost of one of the most elaborate issues must sometimes run into dollars, and there are 150,000 of us in the United States receiving this. All of this of course, must ultimately be added to the high cost of medical care.

What is worse to my mind is its effect on the profession. Most of you are smoking your heads off, not because cigarettes are so delightful, but because you are helpless under the pressure of high-powered advertising. Similarly, you are using the vitamins, the hormones, the latest and most expensive antibiotics in enormous amounts long before they have scientifically proven their worth.

Ramifications of Investigation

Two years ago, Dr. Samuel Levine gave a talk before the Providence Medical Association, in which he pointed out that with good judgment a physician can handle a large proportion of his cases with a minimum amount of expensive investigation. I don't know how many laboratory investigations can be made in a well-equipped, modern hospital. I asked the head of the largest laboratory and he couldn't tell me. There are too many of them. I am astounded at the number of such procedures done on the usual case presented before medical grand rounds. The expense frequently must run into hundreds of dollars.

Now Dubos, in his recent *Life of Louis Pasteur*, pointed out that this genius did not blindly go ahead with every possible experiment. His greatness lay largely in the fact that he shrewdly surmised what procedures could possibly get the best and quickest information. Of course, Pasteur did not always hit it on the head and he had to keep trying. But with the slender resources at his command, he could not afford to work without discrimination.

Our internes and residents learn all about the vast ramifications of medicine. I fear that they get exalted ideas of what constitutes a reasonable amount of investigation. When I send a private patient into the hospital, I am usually disturbed at the carefree way in which his pocketbook is treated.

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*Presidential Address delivered at the 139th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 11, 1950.

Some years ago, I operated upon a patient for cancer of the tongue. He died promptly of coronary disease. I had no electro-cardiogram and when the record was discussed probably I was criticized for not making a full investigation. Yet I knew from the history that he had had coronary disease and still felt justified in removing a mouth cancer at great risk.

How many hospital patients with really serious disease now escape the use of vitamins, hormones, large amounts of intravenous fluids, and enormous amounts of the latest and most expensive antibiotics? Dr. Brunschwig did a number of his tremendous operations in Vienna several years ago. He had access to almost none of these popular, modern agents. He reported that he was surprised to find how well his patients did without them.

The most thorough, painstaking study of vitamins I have seen so far did not support at all the extensive use of them, which is now prevalent. One of the brightest appearing vistas of which we are now getting glimpses ahead of us is the use of hormones. Nevertheless, these hopes and the modern use of hormones are at present far, far ahead of their proven value.

Dr. Gamble, certainly a pioneer in the study of body fluids, has deplored to me the overuse of intravenous fluids. Rarely have I heard a case criticized for the insufficient amount of fluids used.

Use of Antibiotics

Dr. Howe, formerly an interne at Rhode Island Hospital and now doing brilliant work at the Massachusetts Memorial Hospital in Boston, read a paper before the New England Surgical Society on the use of antibiotics. His conclusions were that they were being used frequently without proper indications and in excessive amounts at unnecessarily large costs.

Even Dr. Keefer, speaking before the Rhode Island Dental Society recently, suggested that antibiotics were often being used without discrimination. One of our best known practitioners just told me that he had a case of the prevailing epidemic of influenza or grippe and, at the suggestion of another able man, he ordered chloromycetin for the patient. A few days later she pushed a bill into his hands and said, "Here, you can pay this yourself." The amount was $30. Now according to Dr. Smith, there have been thousands of cases of this sickness in the community. The morbidity was slight; the mortality almost nil; and the worth of chloromycetin is certainly not well-proven as yet in such conditions.

We are getting reports now of penicillin-resistant strains of gonococci, of the serious growth of monilia and other fungi, of adverse effects on patients, following the use of penicillin, streptomycin, and aureomycin. All this suggests caution in the use of these valuable agents.

When Dr. Oliver Wendell Holmes returned from studying with Louis in Paris, he stated concisely what he thought he had learned. One thing which he said, seemed wise to me. I doubt if many physicians are impressed by it. "I learned not to think that I must give medicine because a patient is sick." Another remark of Dr. Holmes' was that the advent of homeopathy in the old days did good, not because of the worth of the system itself, but because it put a check on the tremendous overdosing that the regular physician did in those days. Now if over-dosing was bad with those impotent drugs, how much worse it is today with our modern, powerful agents capable of great good, and equally great harm.

Age of Specialization

This is an age of specialization. None of us have specialized more closely than Harvey Cushing. He said, "No one can be a good physician who has no idea of surgical operations and a surgeon is nothing if ignorant of medicine. It would be an admirable thing if every student before his graduation be required, under the control and supervision of his teachers or the district physician of the community, to engage in an actual house-to-house practice."

When physicians of my age started, practically every specialist in the community had come up through general practice. I still have a great admiration for many of them.

I think that a specialist should be a counselor in all matters relating to his subject and ready to handle all the difficult cases. I don't think he should necessarily have full charge of every patient that would be considered in his domain. Take Pediatrics —In much of the country, a great deal of the pediatrics is handled by the general practitioner. I think a good general practitioner should take care of most children, and always know that he has ready to help him, highly trained men.

There was a time when we general Surgeons thought we were specialists. We now know that by modern standards we are not. A well-trained young surgeon starting in practice now, in some hospitals, can have nothing to do with the skull or its contents if they are not intact. (I once elevated a depressed fracture of the skull, bringing the patient promptly out of his convulsions). He cannot do gynecology. He cannot remove a prostate or kidney. He cannot handle a fractured bone or a dislocated joint. He cannot do a lumbar sympathectomy. He cannot give an ether anesthesia.

Dr. Beecher of the Massachusetts General Hospital recently had an editorial in a surgical magazine, warning against the modern tendency to

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CORTISONE THERAPY IN RHEUMATOID ARTHRITIS*

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On April 13, 1949 Dr. Philip Hench and his associates at the Mayo Clinic published the first clinical report on the use of Cortisone Therapy in Rheumatoid Arthritis. This was the first recorded case in which the reversibility of Rheumatoid Arthritis could be produced by means of a hormonal preparation. Cortisone, or Compound E is the name given to this hormonal preparation of the Adrenal Cortex. This particular preparation was selected by Dr. Hench et al following their brilliant deduction that the remissions in Rheumatoid Arthritis observed during pregnancy or jaundice were likely due to an adrenal factor rather than a unisexual hormone or a compound related to hyperbilirubinemia. Since Dr. Hench's original work the medical world has been eagerly awaiting clinical reports on the reversibility of Rheumatoid Arthritis that have been so amazingly and dramatically brought about by means of adrenal hormone preparations. The authors are pleased to report two cases of interest at the descriptive clinical level in which Cortisone Therapy has been successfully used within a relatively short time of the first published report.

Case No. 1

RM The patient is a 36 year old single female who has suffered from severe Rheumatoid Arthritis for 10 years. During this length of time she has also had a generalized exfoliating psoriasis. Other than the Arthritic and Psoriatic lesions the physical examination did not reveal any pertinent or contributory physical findings. The Arthritis beginning in the fingers of the right hand had within several months progressively and severely involved the fingers of both hands, the wrists, elbows, neck and both ankles. These joints went on to progressive and advanced restriction of motion, stiffness, deformity and finally complete locking of the above joints by established rheumatoid arthritic changes. In the course of the last 3 years, nearly all other joints in the body have been involved with pain, stiffness and limitation of motion but without deformity. During the past 3 years, the patient had been unable to live much more than a wheelchair existence. She had been unable to get in and out of bed, unable to comb her hair, brush her teeth or use her arms and hands properly in order to eat. She has been able to walk only a few steps at a time, and with much needed assistance. The effort required to climb a few stairs has been such that usually the patient has needed to be carried up and down. She had been treated through the years with many symptomatic preparations including heavy doses of Salicylates, two separate courses of Gold Therapy and two courses of Sulphur Therapy without satisfactory response to any type of treatment.

She was admitted to St. Joseph's Hospital on February 1, 1950. At this time she had all of the disabilities described above and in addition the patient did not have any more than 10 to 30% function in any one joint or set of joints, and for the most part was almost completely incapacitated as far as various bodily motions were concerned. In a general way the patient complained of tiredness and a general lack of energy and ambition. She was frequently depressed and discouraged about her progressive disability and weakness.

X-rays of the various joints involved showed extensive changes of Rheumatoid Arthritis with fusion of many joints including the 2nd, 4th and 5th fingers of each hand, cervical spine, both wrists and both ankles.

Laboratory data at the time of admission showed essentially normal values relative to Rheumatic activity. Sedimentation rate 24mm in 1 hour; Cutler method 22 (normal 10); corrected Wintrobe 24; Hemoglobin 14.1 gms; R. B. C. 4,200,000; WBC 7,000; Differential: Polys 66; Lymphocytes 29; Monocytes 2; Eosinophils 3; Serum Cholesterol 227; Blood Sugar 90; Uric Acid 4.3 mgs %; Urea 10.7; Calcium 12 mgms; Phosphorous 3.0; Serum Albumin 4.68; Serum Globulin 2.34; Glucose Tolerance curves showed normal values. These data reveal normal values excepting moderate elevations of the sedimentation rates and the leucocyte count.

Cortisone Therapy was started on February 4, 1950 with an initial intra-gluteal injection of 250 mgms. Since then 100 mgms. have been given intragluteally daily until this writing with the exception of 6 days, representing a total of 10 weeks of therapy.

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*From the Arthritic Clinic and Medical Services of St. Joseph's Hospital, Providence, R. I.

On the 7th day following Cortisone therapy, the patient was for the first time able to partially move the fingers of her right hand. During this day and the day proceeding she observed several short periods which she described as "warm flushings" throughout her abdomen, and "hot flushes" inwardly. No further motion was evident until the 11th day when she noticed that she was able to roll over in bed and arise unassisted and painlessly. At the end of two weeks she was able to move the fingers of both hands so that she had some 50% of normal range of activity, and about 10% activity in the left wrist and 30% motion in the right wrist. She was also able to comb her hair with either the right or left hand. She had about a 50% improvement in motion of her neck from right to left and 25% from left to right. She had about a 2/3 improvement in internal and external rotation of the shoulder joints. At the end of three weeks, she was able to walk up and down three flights of stairs without tiring and to walk 2,000 feet of floor space repeatedly without pain or fatigue. At the end of 3½ weeks she had further but slow improvement in all of the joints mentioned above and in addition could lie on her back in bed and could kick her feet so that her entire lower limbs could very rapidly be flexed and extended through a full 180° arc. During the entire period of observation and treatment the patient has been afebrile.

At the present writing, more than two months after the beginning of treatment the sedimentation rates have progressively fallen to the present levels of Cutler 6 and corrected Wintrobe of 0. The Cholesterol value on 4/8/50 was 177. All previously recorded laboratory tests have essentially unchanged values.

During the first three weeks there was slow but progressive improvement of the psoriatic lesions on the face and neck. All during the Cortisone therapy, there has been a gradual improvement in energy and well being. In addition the patient has not been depressed, rather she has been lighthearted, cheery and hopeful.

Case No. 2

MM The patient is a 40 year old married female with marked Rheumatoid Arthritis of both ankles, the right hand and wrist, the left shoulder and both tempero-mandibular joints of ten years duration. The onset followed a normal pregnancy and delivery. During the same ten years the patient had extensive psoriatic lesions over the abdomen and chest. The findings on physical examination were essentially limited to the joint findings and the psoriatic lesions. Her disability was such that she could walk only 10 or 12 steps because of severe pain in both ankles. She was unable to perform most of her usual household duties. She could not go up and down stairs more than once daily and then with great difficulty. She was able to get in and out of a chair and bed only with great difficulty. She could not turn the light on over her bed. She was unable to move her fingers and wrist so that she could not write or cook without much assistance. She could not open her jaws in order to have necessary dental hygiene. She was unable to get in and out of an automobile without assistance. She always felt tired, "worn-out" and the minimal household duties fatigued her greatly. X-rays of the various joints mentioned showed marked destructive changes consistent with established Rheumatoid Arthritis.

Laboratory data showed a Hemoglobin of 12 gms; R. B. C. 4,020,000; W. B. C. 6,700; Differential—normal distribution of cells; Sedimentation rate (Cutler) 20; corrected Wintrobe 11; Serum Cholesterol 212 mgms %; Blood Sugar 110; Urea 9.8; Uric Acid 3.0; Calcium 12.1; Phosphorous 3.2; Glucose Tolerance curves showed essentially normal values.

The patient was given 100 mgms of Cortisone intra-gluteally on March 28 and since then received 21 such doses in 24 days. Beginning with the third day of therapy she was able to walk up and down 1 flight of stairs without difficulty, and in addition was able to use the sole of her foot in coming downstairs rather than her usual method of employing the heel because of difficulty in motion at the ankle joint. Progressively from the third to the 24th day of treatment she has been able to get in and out of bed without difficulty, to pull on and off the light above her bed and the light on the kitchen ceiling. In one week she was able to get in and out of an automobile without assistance, and to walk about a block and a half without pain, discomfort or fatigue. She has had about 50% more motion in her jaws. In two weeks she was able to do some writing inasmuch as she has been able to address several letters. She has been able to use her hands very satisfactorily relative to eating her meals and can perform almost complete functions of internal and external rotation of both shoulder joints.

Beginning with the third day of treatment, the patient has been energized to such an extent that she has been up at six o'clock in the morning and performing all her daily household duties from 12 to 15 hours a day without fatigue. She has felt so energetic that she has been able to sleep only 4 or 5 hours daily and then she is very eager and cheerful to arise and start another day's activity. This activity represents conditions that never occurred either during the course of the Arthritis or before its onset.

On the twenty-fourth day of treatment, the blood sedimentation values were: Cutler 6; corrected Wintrobe 1; the Serum Cholesterol was 170. All the previously recorded values were essentially as

those reported before Cortisone therapy was inaugurated.

From the 24th to the 32nd day of treatment, 200 mgms of Pregnenolone, orally, has been substituted for Cortisone therapy. During the use of Pregnenolone, she not only has maintained all of her previous improved joint motion but she has also noticed further motion of a slight degree in all joints that were previously improved and successively relieved by Cortisone Therapy. It is also interesting to note that she had the normal amount of pep and energy, rather than an over-compensated amount when she changed from Cortisone to Pregnenolone Therapy. It is further interesting to note that the psoriatic lesions on the body had almost completely regressed during Cortisone Therapy but returned to about 75% of the former extent and severity since changing to Pregnenolone Therapy by mouth.

Discussion

Both of the above patients with Rheumatoid Arthritis present the type of case which before the advent of hormonal therapy, were judged to be among the most severe cases. The 3% of Rheumatoid Arthritic patients who also have Psoriasis run a much severer course than uncomplicated types of Rheumatoid Arthritis. Whereas the response to Cortisone Therapy was relatively late in onset in Case No. 1 certainly it occurred promptly in Case No. 2. It is interesting to note that Case No. 1 had a more severe Psoriasis in that it was generalized and exfoliating, whereas Case No. 2, although severe Arthritis and severe Psoriasis were present the latter was localized to the chest and abdomen. It is further interesting to note that Case No. 1 had partial clearing of psoriatic lesions only on the face and neck, while the second case had nearly complete clearing of all psoriasis present. These cases demonstrated fusion of many joints and it was considered doubtful that joints locked by clinical examination and by x-ray evidence would likely be amenable to Cortisone Therapy. It appears, however, from our results that the extent and severity of Rheumatoid Arthritic and Psoriatic lesions in combination are not barriers to satisfactory reversal of signs and symptoms by means of adrenal hormonal therapy. It is interesting to observe that Case No. 2 had an over-compensated amount of euphoria, energy and pep while on Cortisone Therapy, whereas Case No. 1 merely lost the so-called toxicity associated with Rheumatoid Arthritis in that she had a normal amount of energy. It is further noteworthy that Case No. 1 also had readily recognizable "flushing feelings" throughout the body prior to the onset of joint activity, but these were not manifest in Case No. 2. It is interesting to note that both cases had Cholesterol values at the upper limits of normal at onset of treatment, but had Cholesterol levels that progressively dropped to the lower limits of normal at the time of this writing. This is particularly interesting, in view of the fact that the structural-chemical formula of Cholesterol, Pregnenolone and Cortisone are very similar and points out the possibility of their interchangeability within the body, possibly by some enzymatic modification. Both cases, as judged by the clinical findings, the x-ray findings and the paucity of laboratory findings, represent the so-called "burned-out cases" of Rheumatoid Arthritis or Psoriatic Rheumatoid Arthritis. It is certainly significant that the side effects of hyperadrenalism alleged necessary to reverse Rheumatoid Arthritis have not been encountered in either case.

Bibliography

Hench, P. et al The Effect of a Hormone of the Adrenal Cortex

(Compound E) and of Pituitary Adrenocorticotropic Hormone on Rheumatoid Arthritis — Proc. Staff Meeting Mayo Clinic 24:181:1949

Wassman, K. Rheumatoid Arthritis and Psoriasis — Annals of the Rheumatic Diseases 8:70:1949

Combined Staff Clinics The Adrenal Cortex — Am. Jr. Med. 7:100:1949

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THE MONTHS AHEAD*

R. B. ROBINS, M.D.

The Author. *R. B. Robins, M.D., of Camden, Arkansas. Past President, Arkansas Medical Society; Member, AMA Co-Ordinating Committee; Professor, Medical Economics, Arkansas School of Medicine; Speaker, Congress of Delegates, American Academy of General Practice; Democratic National Committeeman from Arkansas.*

I AM PROUD to be in Rhode Island. Rhode Island has given an outstanding demonstration of what can be done by the voluntary process. And at the same time it has shown to the nation that the *Independent Man* personified in stone atop your State House is very much a living personality in the hearts and minds of the thousands of people who make your State one of the leaders in spite of its small geographical position.

We, in other States, were astonished in 1944 when we read that your then Governor, Honorable J. Howard McGrath, had proposed to your General Assembly that a compulsory hospitalization insurance law be enacted. And we were heartened later that year when we read of the work done by a Voluntary Advisory Council on Health, composed of your citizens from all walks of life, which explored this compulsory proposal thoroughly, and discarded it as not the means to achieve the goals which we all seek in health care.

Industry and labor in this State responded to the challenge and proved that by their joint effort they could do a far greater job on a voluntary basis than by any other method. In 1944 you had approximately 40% of your eligible population covered through Blue Cross. Today, six years later you have 76.3% of the eligible population, and your program has the highest enrollment in the country in proportion to population.

Surgical Plan Progresses

Your own Medical Society surgical-medical plan, started the first of this year, has had the fastest growth of any similar plan in the country, and I am informed that by the end of this month Physicians Service will have enrolled almost 50,000 subscribers,—one-seventh of your eligible population.

*Presented at the 139th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 10, 1950.

And since your Society has also taken a liberal viewpoint, and has endorsed a program of voluntary surgical insurance as sold by private insurance companies, your efforts to extend medical care to the people of Rhode Island are indeed to be lauded. Certainly these several efforts have indicated clearly that it is the desire of the public generally to insure themselves against the costs of illness, and not have any federal agency impose increasing taxes for services that would be far less adequate.

The months ahead are not only vital to American medicine—they are vital to America's way of life. My dear colleagues, let me stress and emphasize to you at this very moment with all the strength and emphasis at my command that this is the year of decision for us. I refer to the elections this fall. The elections this year will decide whether the American doctor remains *free* or whether he becomes *slave*. We must elect Congressmen and Senators and Governors who have the courage to stand out against any compromise on American principles. If that isn't done — then we might as well fold our tents and slip quietly into the night of statism.

Socialism Must Be Halted

In the months ahead every doctor must do everything in his power to stop the march of socialism in this country. This is in no sense a matter of party politics. The issue is far above partisanship. Each doctor, as an individual citizen and within his own party, has the right—and more important, the duty —to work for the election of candidates whose views reflect the principles which we believe are of fundamental importance not only to our profession but to our Nation.

It is not the place of any organized medical society to engage in political activities—indeed, it would be wrong for any medical organization to do so. Each doctor as an individual, however, is a free citizen and a free political agent. Every doctor in his own district and his own state has the obligation in this year of decision to give support to the candidates of his choice—the candidates who are on the side of freedom. I hope that in every state doctors will help in the formation of political-action committees on a state level for the purpose I have indicated. They must draw into these committees many allies—dentists, druggists, business men, housewives and others.

Ladies and gentlemen, you have so much at stake in this matter. Unfortunately there are many among us who do not seem to realize it. Won't you go home from here and alert your colleagues? There is, my friends, the most urgent need for all doctors to become crusading citizens at this time when our whole American way of life is threatened.

Please don't leave it to George. There are too few Georges. You yourself must make this fight for your professional life. Your efforts must count on election day, and we must let the socializers know that they are going to count. You must vote —every eligible member of your family must vote —all of your friends must vote. The doctor who doesn't vote this year and who doesn't actively work in this campaign to prevent socialization of medicine is not only letting down his profession, and all the men in public life who have championed medicine's cause; he is also letting down his country—and inviting destruction of the system under which he lives.

If you are not going to do these things that I have indicated, my friends, then prepare yourselves to accept political dictation from Washington—don't protest too much when you wake up some morning to find yourself a captive-citizen, with the socializers and the ambitious Caesars of politics as your captors. That's the price free people have always paid when they failed to prize their freedom enough to defend it.

The outcome of the recent senatorial election in Florida should be very pleasing to all of us. This was a clear-cut demonstration of voter sentiment against the trend toward socialism in this country. Senator Pepper has been an arch advocate of State Socialism. His rejection by the people of Florida should serve as a warning to the present Administration that the American people are fed-up with socialistic legislation. It is highly significant that National Compulsory Health Insurance was one of the major issues in that campaign. Senator Pepper openly endorsed political medicine. Mr. Smathers, on the other hand, vigorously opposed Compulsory Health Insurance and the entire socialistic program. It can be said that "Left Wingism" suffered a setback in Florida as it has in Great Britain and Australia and New Zealand, which indicates that voters are getting tired of high taxes, big promises and big expenses.

Deficit Spending

I have recently been in Virginia and had a visit with their Governor—Governor John S. Battle. It was inspiring to me to find the type of loyal Americans who hold high political office there. We need more fighters like Senator Robertson and Virginia's esteemed senior Senator—Harry Flood Byrd—to combat the schemes that are being concocted to transform the United States of America into a Socialistic State. May I remind you that these gentlemen are Democrats too. Not all Democrats are socialistically inclined.

The State of Virginia is extremely fortunate in having two gentlemen in the United States Senate who come closer to exemplifying and activating the principles of Thomas Jefferson and Andrew Jackson than do the nominal leaders of the Democratic Party at the present time. Senator Byrd truly called the turn when he recently warned that our present Washington Administration is traveling a "non-stop, high-speed highway to socialism." I, holding the office of Democratic National Committeeman for the State of Arkansas, subscribe to Senator Byrd's warning that deficit spending by our Federal Government is leading our nation into bankruptcy. Another great Virginian and, by the way, the founder of the Democratic Party—Thomas Jefferson—once said: "I place economy among the most important virtues, and public debt as the greatest of dangers to be feared."

I would like to remind you that another outstanding Democrat—Franklin Delano Roosevelt—said in Pittsburgh, October 18, 1932: "If a nation is living within its income, its credit is good. If in some crisis it lives beyond its income for a year or two, it can usually borrow temporarily on reasonable terms. But if, like a spendthrift, it throws discretion to the winds, is willing to make no sacrifice at all in spending, extends its taxing up to the limit of the people's power to pay, and continues to pile up deficits, it is on the road to bankruptcy." That was true when Roosevelt said it and it certainly must be true now.

I called to your attention with pride a speech made on the floor of the United States Senate on last February 22 (Washington's Birthday) by my close friend and neighbor in my home town—the distinguished Senior Senator from Arkansas—Senator John L. McClellan. The speech dealt with Fiscal Policies and the Administration's Legislative Program.

Senator McClellan called attention to the dangers inherent in the incurring of large annual deficits. All of you know that we are going in the hole over five billion dollars every year. Senator McClellan took for example just 15 bills now pending in Congress to carry out the President's legislative program. If these 15 measures should be enacted into law, they will increase the annual cost of the federal government by 25 billion dollars. The 25 billion dollars added to our present 43 billion dollar budget will raise the annual federal expenditures to above 65 billion dollars. What would that mean in the way of taxes for us? It would mean that you and I would have to pay 40 cents out of every dollar we earn in taxes.

All of us are concerned about the months ahead. We certainly should be. It seems to me that we are

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living in a very uncertain world—conditions are such that there is a general anxiety as to what the future may hold for us.

Don't you know, my friends, that the Russians must be watching with a great deal of pleasure our deficit spending and our increasing indebtedness. This cannot continue without ending in bankruptcy for our country and nothing would suit the Russians better than to see us crash economically. When that happens, we will be easy picking for Communism.

Doctors are not only doctors—they are citizens as well. And, as citizens, they are concerned about the whole social order. We have all read our histories—we know about the rise and fall of nations—we know about the fall of the Roman Empire—we have watched with our own eyes the disintegration of the British Empire—and *now we are concerned about our own nation in the world of nations.*

We have fought two recent wars against aggression and totalitarianism—against the philosophy of dictatorship—against the idea of too powerful a central government control over the lives of people. Yet, we see the tendency in our own Nation to more and more turn over power to the central Government—to give Washington more and more control over the lives of the American people as subject citizens.

When you and I were young our parents taught us self-reliance. Now the tendency is to teach us not to rely upon ourselves, but to rely on the Government. (I have a 50-cent piece here in my hand. I note that it says on there "In God We Trust." Before you know it someone will suggest that we change it to read "In Government We Trust.")

Dr. J. S. Sanders of Leland, Miss. recently sent me this revised version of the 23rd Psalm:

"The State is my shepherd: I shall not work.
It maketh me to lie down on good jobs;
it leadeth me by the still factories.
It deadens my soul; it leadeth me in the
paths of idleness for politics' sake.
Yea, tho I walk through the valley of
slothfulness and economic disaster, I
will fear no evil, for it will be with me;
its dole and paternalism they comfort me.
It prepareth a Utopia for me by appropriating the earnings of the frugal;
it filleth my head with fool expectations,
my mounting ineffeciencies runneth over.
Surely goodness and mercy shall follow
me all the days of my life; I shall
live on the bounty of the State forever."

Security and Freedom

SECURITY—SECURITY—SECURITY is the word we hear all the time. Yes, you can have perfect SECURITY in a jail—food—shelter—clothing—medical attention, *but there is one thing you cannot have and that is freedom.*

We seem to accept freedom as a matter of course. Freedom is not free. It is only preserved by effort and eternal vigilance. We must, as citizens, alert our fellow Americans that the Government cannot furnish "something-for-nothing." Whatever is given from Washington must be at the people's own expense.

The social planners pay no heed to the fact that their programs add tremendously to the tax load of the American people. The tax bill is worrying the citizen today much more than the medical bill. Hidden taxes are fooling the man on the street. The Tax Foundation tells us that there are 150 different kinds of taxes levied on the manufacture and sale of a woman's hat; 116 different forms of taxes on a man's suit of clothes.

Businesses naturally do everything possible to pass on to their consumers practically all tax increases. The man on the street should never be fooled about that—he pays those taxes in the form of a higher price for every product that he buys.

Governments in the past gained power by the sword,—now they use the more subtle weapon of money. They use the method of taxes to drain away the earnings of the people and then they dole some of it back to them in the form of subsidies and grants-in-aid. In this way they become *masters* of citizens rather than *servants*. The people go to the Government for support instead of the Government's going to the people. Hitler used this method in Germany.

In America today you will note that Governors of States, Mayors of cities and even business organizations go to Washington as beggars only to have returned to them money which the Government has previously taken away from them in the form of taxes. Of course, as you all know, this money is returned to them minus the Federal brokerage fee. It is not the same dollar that was originally sent to Washington—it is a dollar smaller than the dollar that was sent. A dollar never gets any bigger by making a round-trip to Washington.

The hand-out state is only made possible by the hand-in taxpayer. The question for people to ask themselves today is: *Who can spend my dollar best? The government or I?*

If you will think about it for a minute—most of the present socialistic philosophy is based on the idea that the Government can spend your dollar better than you can spend it.

So many times I hear doctors say and other citizens too—"What can I do? I am just one individual—just one drop in the bucket." If any one of you has taken that attitude—then, I ask you: "What would happen if every other individual in America took the same attitude?" We would lose by default, wouldn't we?

The Physicians' Role

I say to you that each of you as an individual is important in this fight. Don't sell yourselves short. The tendency of modern times is to make the

individual unimportant. The average man feels wholly inadequate to cope with the many complex situations he faces. He asks himself "What can one man do, anyway?" and arrives at the conclusion that others are better fitted than he to take the responsibility, so why concern himself too much about present day problems. That is taking an inferior attitude — that is taking a defeatist attitude. Most of your limitations are self-imposed. A 'do-nothing' attitude is inexcusable. Don't sell yourselves short, because in the months ahead you can do a wonderful job for the future of American medicine and the future of your country.

It behooves you to take a keen interest in political affairs. Democracy functions through politics as you well know. It is inconsistent for us to criticize actions of politicians, while we ourselves evade political service or interest in political affairs. Doctors have a tremendous political potential with their patients and friends if they would only use it.

The medical profession of America is concerning itself more than ever before about the trend toward socialism in this country. We realize that socialized medicine is just one part of the structure of complete socialism.

Never before in the history of the American medical profession has there been so great a need for united effort by all its members—regardless of regional or geographic differences, political differences, racial or religious differences, or professional differences.

This is the reason for the National Educational Campaign of the American Medical Association.

Membership in the American Medical Association having been automatic and without financial obligation all these years—a tendency has developed to take the Association for granted, and not really appreciate it. It is too seldom realized that the entire framework of medicine in the United States today is due primarily to the activities of the American Medical Association.

Just think of the improvement in standards of medical education, the fights against quackery, the improvement in hospital standards, the work of the Council of Pharmacy and Chemistry to protect the public against unacceptable drugs, and the many other Association activities that have had to do with giving the public the best possible in medical care! All of these things have been done *voluntarily* by your National organization. There has been no government compulsion about it. It seems to me that it is time that members do something for their Association. If a manicurist can pay her union $36 in dues annually, it seems to me that any doctor should be ashamed to complain about having to pay $25 for membership in his National organization. I would like to say that any doctor who refuses to pay his membership dues this year in the American Medical Association is, in effect, voting for the socialization of medicine by not supporting the organization which is protecting him against it.

It is impossible to conduct the Educational Campaign without receiving some criticism about this and that. Some of this criticism comes from within the profession and some without and sometimes over rather petty things. I want to mention one such thing right here, because it is close to my heart. This campaign began over a year ago. Just after it started I met a friend of mine in Chicago and over the dinner table he said to me: "Bob, why don't you take that old classic picture "The Doctor" by Sir Luke Fildes and put some script under it like this—"Keep Politics Out of This Picture." I thought it was a good idea and had him present it to Whitaker and Baxter, the campaign directors. They adopted it and have used that picture in this campaign and I am very proud to have hanging in my reception room the No. 1 copy, autographed by the man who originated the idea.

We have had some criticism regarding the use of this classic picture—some saying that it is not modern—that there is no science in the picture—that the picture is "dated", etc. As Mr. Whitaker has said—"the picture *is* 'dated', if viewed literally, but on the same basis a great many other things are 'dated', including the Oath of Hippocrates, the Bible, the works of Dickens, the works of Shakespeare. Yet in meaning they still are vital and pertinent, even though the language is not of our era.

"Similarly, the painting of "The Doctor" is dated; the physician, the patient and the surroundings have all changed, in outward appearances. But the compassion in that doctor's face—and his concern over his patient—are characteristic of a good doctor today, as they were then, and if modern practitioners ever come to a point where they believe scientific knowledge can replace personal interest in the welfare of those who depend on them for life and healing, then we will have lost one of our most effective arguments against Government-controlled medical practice.

The Fildes' painting of "The Doctor", even though it is old-fashioned, portrays something which is beyond value to the medical profession. To the public it makes sense to say "Keep Politics Out of This Picture", and the best evidence of the picture's effectiveness is the mighty effort our opponents have made to discredit it. If it weren't effective, the socializers would have ignored it, instead of writing thousands of words to complain about it.

"The Doctor" isn't just an outdated painting. It is a vivid portrayal of the vitally important physician-patient relationship which has made doctors something more than medical technicians. And that

continued on next page

relationship is out-dated only in countries which have adopted socialized medicine."

Medicine's Positive Campaign

So much for that. Medicine has a *positive* campaign, as well as a defensive one. We are not just "againsters." There are some things we are for. We are for VOLUNTARY HEALTH INSURANCE. It is increasing rapidly. Very shortly half of the population of the United States will be covered by some form of Voluntary Health Insurance.

Plans to stimulate the improvement and extension of Voluntary Health Insurance systems, to take the economic shock out of illness, are progressing well. If the Government will stay out of this field for another year or so, the American people will solve their health problem voluntarily and in the democratic American way. There is nothing the Government can do for the individual in the field of health insurance that the individual cannot do better for himself and at far less expense. Already, both commercially-sponsored and non-profit, medically-sponsored groups are working on three highly significant projects: (1) broader protection for *individuals* on a "non-group" basis; (2) further protection for the aged; and (3) greater coverage for "catastrophic", that is, extended, expensive illness.

Legislation should *not* be necessary to meet the general problem of prepaid medical care. This is a problem that can best be met by public education and diligent work to improve the Voluntary systems. We must educate people to consider health insurance as a family essential, rather than a luxury. Doesn't it seem strange that people should be more careful about insuring their automobiles against damage than they are about insuring their wives and children against accident and sickness. My friends, this matter is going to require *education*, not *legislation*.

There are many other things that I might discuss, but I have already talked too long I fear. In closing, I would like to say that if we doctors of America want to remain free doctors—if we want to continue by our own initiative and judgment the work that has made America the healthiest great Nation in the world,—we must decide now to assume in full our duties as private citizens. We must inspect our own house, and see that it is kept immaculate. We must give unstintingly of our support to those who can maintain in local, State and National legislative bodies the eternal vigilance that is the price of our precious American freedom. *It is our year of decision.*

Paraphrasing the words of a great Democrat of a few years ago—William Jennings Bryan—We say to Mr. Truman, Mr. Ewing and all the others who are trying to socialize us: *You shall not press down on medicine's brow this crown of thorns, nor crucify us on the cross of tyranny.*

ELABORATION IN MEDICINE

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elaboration of anesthesia. Ether has been used for over a century now in millions of cases and it is still believed by, I think, most of us, to be the safest and, on the whole, the most efficient agent.

One of the most important aspects of modern surgery is the improvement in anesthesia. These experts can do wonderful things with intravenous, intratracheal, positive pressure, and other types of difficult procedures. That, to my mind, is no sufficient argument for putting all anesthesia beyond the reach of the rest of the profession.

Strangely enough, the intelligentsia of our profession, the internists, those who were formerly said to know everything and do nothing, have resisted this movement towards over-specialization. The internist can still treat an infectious sore throat, pneumonia, any type of heart disease not requiring surgery, the complex diseases of the liver, many of the pathological conditions in the intestinal tract, kidney disease, diabetes, and all the other hormonal diatheses.

I am not arguing that anyone with a medical degree should have no further restraints put upon him. I have seen too many sad examples of what this produces. If I went into a strange town I should wish to find institutions where I felt there were careful discriminations as to the type of work done there.

But I know of one man who does nothing but endoscopies. It would be a mistake to deny these examinations to other well-qualified men whose fields are not so narrow.

All these modern developments which I have spoken about command my profoundest admiration. I only ask that we use a little more restraint in the application of them.

I love to quote Latin when Dr. Donley or Dr. Walsh are here to guide and interpret for me. There is a sonority about the language which pleases my ear and an accuracy of meaning which pleases my understanding. "In medio tutissimus ibis." "It is safest in the middle" is rather an exact translation. The human mind is partial to extremes. We are ultra-conservative or rabidly radical. I hope you will believe that I appreciate all these great things that you are doing. I merely worry lest you over-do them.

In a recent publication of one of our most learned medical societies, I have read this by an official of a medical school: "No matter how greatly we may lament the fact, the old family doctor is passing away in the growth of specialism, group clinics, and hospitalization of the sick. The personal relations between the physician and the patient are disappearing in the routine of technical diagnosis, mass treatment, and mass prophylaxis." Many thoughtful men are now warning us that this must not be so.

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The RHODE ISLAND MEDICAL JOURNAL

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DECISIONS OF DELEGATES

The report of the actions of the House of Delegates at the May meeting are reported elsewhere in this issue. The complete reports of committees providing the basis for some of the decisions of the Delegates will also appear in the Journal for the information of all Fellows.

Attention is particularly drawn to several important actions taken at the May meeting of the House. The by-laws of the Society have been amended, and the approval of the amendments has subsequently been accepted by the Society at the General session on May 11. The health insurance committee, and Physicians Service were given wholehearted support in their task of extending the voluntary insurance programs sponsored by the Society.

The problem of uniform fees for all governmental agencies was resolved with the adoption of a complete schedule which is to be printed and distributed to every Fellow of the Society, and also distributed to all agencies concerned with providing medical care for wards and dependents of government. This is an important work, and the schedule of fees, uniform for all agencies, should help solve what has been a problem in recent years as each government bureau sought a schedule of its own.

Two years ago the Society took active leadership in seeking a higher fee for physical examinations performed for life insurance companies. Fees had not been raised for fifty years. Recently, as the committee on medical economics has noted, many large companies have improved their fee schedule in keeping with present day costs. The House noted with interest the action of the companies, but it reiterated its previous stand that the fee for the initial examination should be a minimum of $10.

The committee on public policy and relations which has done outstanding work during the past twelve month period, proposed, and received approval for continuance of its study of the possibility of a director of public relations to work under the jurisdiction of the executive secretary, and to hold a press conference for editors of daily and weekly newspapers in the State.

These are but some of the highlights of the Delegates meeting. Every Fellow has the responsibility to read the minutes of the meeting in order that he may be familiar with the policies adopted for his Society.

PHYSICIAN POPULATION

For the first time since 1942 the American Medical Association has issued its directory of physicians licensed in the country. The task of tracing addresses of physicians has been an extremely difficult one, due in great measure to the dislocation of doctors as the result of the war.

continued on next page

The advance notice relative to the directory indicates the listing of the largest medical population in the history of the country. However, the tabulations presented in this voluminous report must be carefully considered by anyone who attempts to evaluate the physician ratio to population for medical care.

The Rhode Island section of the directory lists 993 physicians for our estimated 743,000 population. But the 993 total includes approximately a hundred physicians who are completing resident and intern training, physicians who are with the armed forces, many of whom are now completing residency training outside Rhode Island, and physicians who are affiliated with government facilities.

The medical population available for general medical care is further depleted by the fact that the directory includes all physicians whether in practice or not. Many of our doctors have retired from practice because of age or illness.

A clearer picture of the medical population of the State should be available later in the summer when the executive office completes a planned study of the physician population.

MEDICAL WITNESS

Our attention was directed recently to a situation in which a physician was issued a subpoena to be a witness in a court case. He complied with the summons, travelling some fifteen miles from his office, and spending a good part of his busy day testifying in court. His compensation was three dollars, the minimum witness fee.

Unwittingly he did not appear merely as a witness, but as an *expert* witness. Physicians should be wary of such a situation, and if summoned to a trial should answer only as a witness of fact. If an opinion is sought in such cases involving the technical and skillful knowledge of the physician as an expert, he should withhold his opinion until he is assured of the reasonable fee allowed an expert witness.

PHYSICIANS SERVICE

Physicians Service, the voluntary non-profit surgical-medical program of the Society, has had exceptional growth in its first five months of operation. By the end of May the estimated enrollment was more than 50,000, thus making our program one of the fastest growing ones of its type in the nation.

The response of the physicians and their cooperation in meeting the varied administrative regulations has been excellent. We have approximately 650 participating physicians, with new names being added monthly to the list. Certainly the participating physician roster includes all but a small number of the fellows of the Society in active practice in Rhode Island.

The program is being efficiently operated by the staff of the hospital service corporation working under the guidance of a joint operations committee that includes three members of the Society. In the first four months of operation the Service paid out in surgical-medical claims $41,419, and for operation expenses $6,534.14, and retained a reserve fund of $25,148.06.

The program faces many tests in the months ahead as it continues its progressive growth. The first of August will start the eligibility period for maternity benefits for the first subscribers, a factor that may affect the reserve fund. But the program has been established on as sound an actuarial basis as possible, and we anticipate that by the end of the fiscal year Physicians Service will rank as one of the leading voluntary surgical-medical plans.

MODERN OBSTETRICS

Now that we are either in, or approaching the second half of our Century, depending on personal views of the matter, we suppose we may expect just about any unusual innovation.

Obstetrics was co-sponsor of one such modern adaptation of the scientific age last month when the first cry of a newborn baby girl at the Albany (New York) hospital furnished the power which through broadcast soundwaves started a motor to raise a curtain placed in front of the new laboratory building of a large pharmaceutical company in Rensselaer, seven miles away. For timing its arrival to meet the opening day festivities at the pharmaceutical company, and for furnishing the "lung power" to generate the scientific gadgets of this modern age, the baby received a $3,000 college scholarship to be utilized some eighteen years hence.

Such are the wonders of obstetrics in this mid-century. We regret we are among those who were born fifty years too late!

ELABORATION IN MEDICINE

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This paper has mentioned sketchily the over-elaboration of medical sales' literature, elaborate diagnostic procedures, the carefree use of medicines, and the tremendous modern stress of specialization. If you continue this expensive over-elaboration, then a paraphrase of an old remark will be brought home to you—Ninevah, nor Tyre, nor Carthage are not more dead than the private practice of medicine.



Ubaldo E. Zambarano, M.D.

President,

January 9, 1950 — May 29, 1950

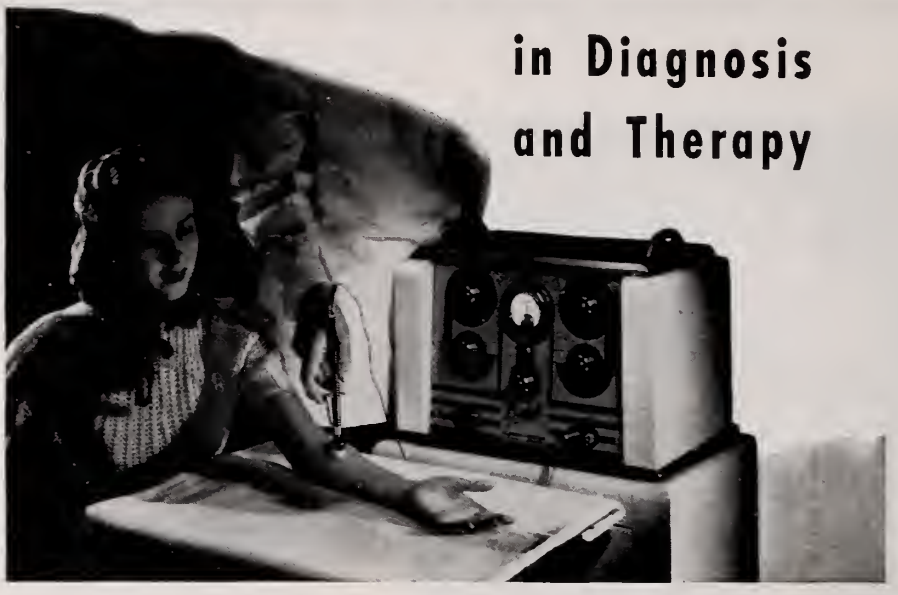
The Providence Medical Association

With the death of Doctor Zambarano our largest district medical society has lost its President and leader. The medical profession of Providence, and of Rhode Island, has lost a beloved colleague whose generous nature, unceasing efforts to improve medical care, and outstanding cooperation in matters relating to public health made him an inspiration to all of us.

But the loss to the people of this State cannot be truly realized at this time. It is to be doubted that anyone, physician or layman, had greater interest, truer concern, and firmer devotion to service in the treatment and care of those afflicted with tuberculosis. He had devoted his entire professional life to this work, and his reputation for sound and constructive thinking on tuberculosis treatment had reached far beyond the confines of little Rhode Island.

Many national and regional honors came to him from medical organizations, but his greatest happiness seemed to stem always from his service to the patients he attended in his years at Wallum Lake and with the Providence Tuberculosis League. The lives he saved through his devotion to his medical practice speak far more eloquently of his greatness than any words we may write.

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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Regular Session Held on May 3, 1950

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, May 3, 1950. The meeting was called to order by the President, Dr. Peter Pineo Chase, at 8:15 p. m. The following were in attendance:

Kent County
Rocco Abbate, M.D.
Peter C. Erinakes, M.D.

Newport County
Donald R. Fletcher, M.D.
Frank Logler, M.D.

Pawtucket Medical
Edward H. Trainor, M.D.
Earl J. Mara, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
Henry Turner, M.D.

Washington County
Louis Morrone, M.D.
Samuel Nathans, M.D.

Woonsocket County
George Keegan, M.D.
Joseph McKenna, M.D.

Bristol County
Charles E. Millard, M.D.
(Alternate Delegate)

Providence Medical Association
J. Murray Beardsley, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
John Dillon, M.D.
William J. H. Fischer, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D.
Robert G. Murphy, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Michael J. O'Connor, M.D.
Edwin B. O'Reilly, M.D.
Alfred L. Potter, M.D.
Louis Sage, M.D.
Daniel V. Troppoli, M.D.
George W. Waterman, M.D.

Officers
Peter Pineo Chase, M.D.
Charles J. Ashworth, M.D.
Morgan Cutts, M.D.
G. Raymond Fox, M.D.

Also in attendance were Drs. Robert C. Hayes, Roland Hammond, Reuben C. Bates, Herman C. Pitts, Charles L. Farrell, and Mr. John E. Farrell, Executive Secretary.

Report of the Secretary

Dr. Morgan Cutts presented his report listing the major actions taken by the Council of the Society since the previous meeting of the House of Delegates as follows:

Since the previous meeting of the House of Delegates the Council has held one meeting. Major actions taken include the following:

Dr. Reuben C. Bates, secretary of the Medical Milk Commission of the Providence Medical Association, was asked to serve as a delegate of the Society to a meeting called by the Local Dairymen's Cooperative Association and the Rhode Island Milk Dealers Association to consider the formation of a non-profit corporation to provide for milk quality control program for the state of Rhode Island.

Dr. Daniel V. Troppoli, secretary of the Providence Medical Association, was nominated to represent Rhode Island on the national committee arranging for the Seventh Annual National Conference of County Medical Society Officers.

The report of the Committee on Diabetes was received and the Committee was commended for its excellent program in connection with the Diabetes Detection Campaign in 1949.

The question of listing of specialties in the classified section of the telephone directory immediately following the name of a physician was referred to the Committee on Medical Defense and Grievance for study.

The question of a relief physician for Dr. Lorenzo Orlando of Block Island in order that he might take a brief vacation was referred to hospitals in the area.

It was voted not to send a representative to the meeting on National Emergency Medical Service to be held in Chicago on May 6, 1950.

The report of the Board of Trustees relative to the necessity for installing a new boiler in the Medical Library was received and the action of

continued on next page

the Board in the matter approved. The Trustees were authorized to make a further report later relative to possible changes in the heating system of the Library.

The financial report of the Treasurer for the fiscal year 1949 was received, discussed, and approved. It was moved that the President should appoint a long range finance committee to consider the financial system of the Society.

The Committee on the Library was requested to consider the possibility of some plan for establishing an organization of "friends of the Medical Library" to aid in its support and maintenance.

The Treasurer was authorized to send out for the American Medical Association notice of dues payable to it for the year 1950.

A report from the Committee on Public Policy and Relations on work of that committee was received and filed.

A slate of nominees was prepared for recommendation to the House of Delegates at the meeting of that body on May 3, 1950. In view of pending recommendations of the Committee on the Revision of the By-Laws that would eliminate the office of Assistant Secretary, the Council has made no nomination for that office.

* * *

The report as presented was accepted and placed on file.

Representation on Rhode Island Quality Milk Incorporated:

Dr. Reuben C. Bates reported to the House regarding the formation of a non-profit corporation to supervise a laboratory for milk inspection in Rhode Island on a voluntary basis. He reported that he had been authorized by the Council of the Society to attend an organization meeting of the corporation consisting of representatives of farms, milk dealers, and civic organizations.



. . . Providence Journal Photo

Dr. Peter Pineo Chase, retiring president of the Rhode Island Medical Society, hands gavel to incoming President, Dr. Charles J. Ashworth (right), as Vice President, Dr. Robert T. Henry, observes the ceremony.

The corporation desires that one of its directors shall be a representative of the Rhode Island Medical Society. The matter was discussed and Dr. G. Raymond Fox moved that the President be authorized to appoint a Fellow to represent the Rhode Island Medical Society on the Board of Directors of Rhode Island Quality Milk Incorporated. The motion was seconded and adopted.

Communications:

The Secretary read a communication from the American Medical Association relative to a letter being sent by it to every intern and resident in the country regarding the issues pro and con on Compulsory Health Insurance. A copy of the brochure sent with the letter was distributed to the House of Delegates.

The Secretary read a communication from Mr. Arthur Devine, State Director of Labor, announcing his desire to appoint Dr. G. Raymond Fox as a representative of the Society on the Advisory Committee to the State Curative Center, to succeed the late Dr. John F. Kenney. The motion was made, seconded and passed that the appointment of Dr. Fox be approved by the House of Delegates.

The Secretary reported a letter from the American Medical Association urging the cooperation of physicians in filling out schedules prepared by its Bureau of Economic Research and the United States Department of Commerce, for a survey of physicians incomes.

Report of the Treasurer

Dr. G. Raymond Fox, Treasurer of the Society, submitted his annual report for the fiscal year of 1949 amplifying the report previously submitted to the House of Delegates with explanation of the expenses for the operation of the Society.

Dr. Louis I. Kramer moved that the annual report of the Treasurer for the fiscal year of 1949 be accepted and placed on file. The motion was seconded and adopted.

Recommendations from the Council

The Secretary reported to the House that the Council had submitted a list of nominees for officers and standing committees to serve for 1950-51. Dr. Chase asked if there were any counternominations to the slate proposed.

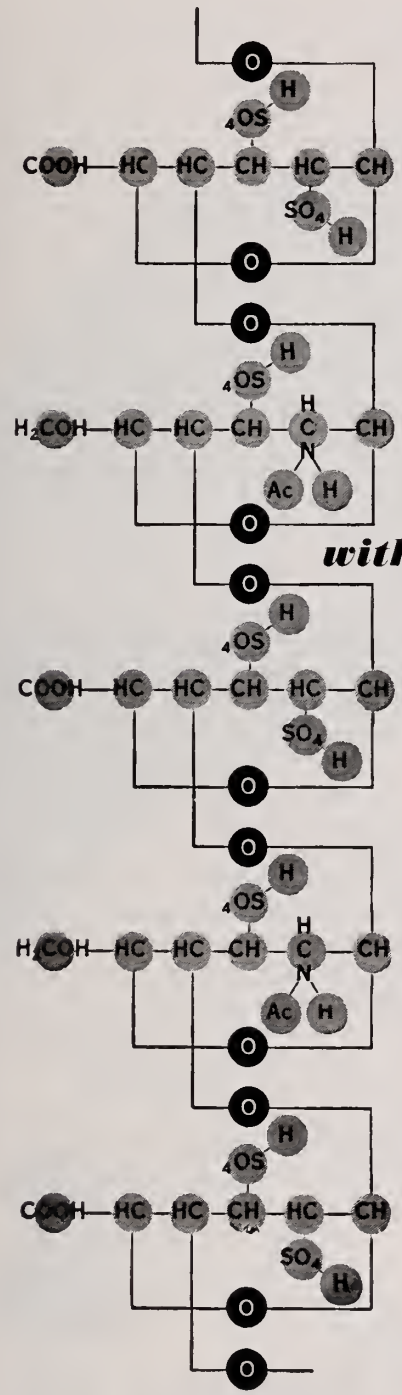
Dr. John Myrick placed in counternomination for the office of President-Elect, Dr. Albert H. Jackvony.

There being no other counternominations it was moved that the slate of nominees be closed. The motion was seconded and adopted.

Dr. Earl J. Mara moved that the House of Delegates authorize the Secretary to cast one ballot for it for all offices except that of President-Elect, and for all standing committees as submitted to the House by the Council. The motion was seconded and adopted.

On a written ballot for the office of President-Elect Dr. Herman A. Lawson received eighteen

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HOUSE OF DELEGATES

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votes and Dr. Albert H. Jackvony fifteen votes and therefore Dr. Lawson was declared elected to the office of President-Elect.

Report of the Committee on By-Laws

Dr. Roland Hammond, Chairman of the Committee for the Revision of the By-Laws, read the summary of the changes proposed by his committee. He submitted to the House for its decision the question of whether the Committee on Medical Defense and Grievance should be a standing committee or an appointed committee. After brief discussion, Dr. G. Raymond Fox moved that the Committee on Medical Defense and Grievance be an appointed committee of the Society and not an elected standing committee. The motion was seconded and adopted.

Dr. G. Raymond Fox moved that the amendments to the By-Laws proposed by the Committee be accepted and approved by the House of Delegates with recommendation of their adoption to be made to the membership at the General Session on May 11, 1950. The motion was seconded and adopted.

Committee on Medical Defense and Grievance

Dr. Roland Hammond submitted the report of the Committee on Medical Defense and Grievance which he discussed briefly.

The motion was made and adopted that the report of the committee be received and placed on file.

Committee on Uniform Fee Schedule for Governmental Agencies

Dr. Herman C. Pitts discussed the report of the Committee for a Uniform Fee Schedule for Governmental Agencies which had been previously submitted in printed form to each member of the House of Delegates.

After explaining the decision of his committee, Dr. Pitts moved the adoption of the report of the committee, and also moved that if the House accepted the report and the schedule submitted, that the fees be printed in booklet form for distribution to the Fellows of the Society. The complete motion was seconded and unanimously adopted.

Committee on Medical Economics

Dr. Samuel D. Clark, Chairman of the Committee on Medical Economics, briefly discussed the report of his committee which had been submitted in advance to each member of the House. He raised the question of whether the House wished to change the decision previously taken by it regarding fees for physical examinations for life insurance companies. The question was discussed by members of the House and it was the general opinion that the previous action regarding these fees taken by the House of Delegates should be reaffirmed.

Committee on Public Policy and Relations

Dr. Charles L. Farrell, Chairman of the Committee on Public Policy and Relations, discussed his report as submitted to the House. He related the many activities of the committee during the year and he demonstrated various media used to carry on an educational program with the public and with the profession. He urged the Society to encourage the component groups to make every effort to cope with the problem of emergency medical calls.

It was moved that the report of the Committee on Public Policy and Relations be adopted. The motion was seconded and carried.

Committee Reports

Dr. Chase called to the attention of the House that the Committees on Health Insurance, Industrial Health, Library, Publication, Scientific Work and Annual Meeting, Public Laws, and the Report of the Board of Trustees and of the Rhode Island Medical Society Physicians Service, had been submitted in writing to the Secretary and a copy had been transmitted to each member of the House.

He stated that unless the House had any questions to ask or comments to make regarding these reports, he would entertain a motion for their acceptance.

The motion was made that the reports of these committees and boards be accepted and placed on file. The motion was seconded and adopted.

The House adjourned at 10:20 p. m.

Respectfully submitted,
MORGAN CUTTS, M.D., *Secretary*

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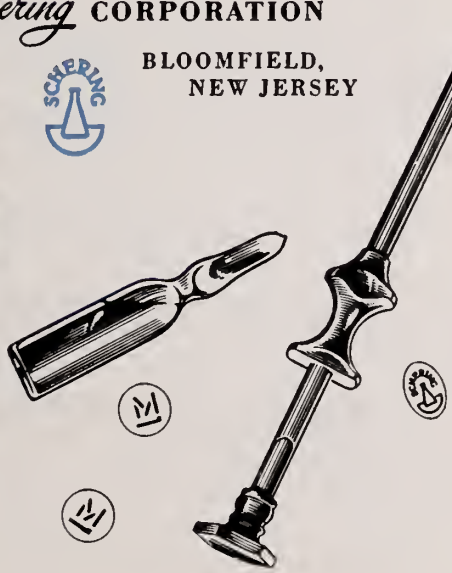
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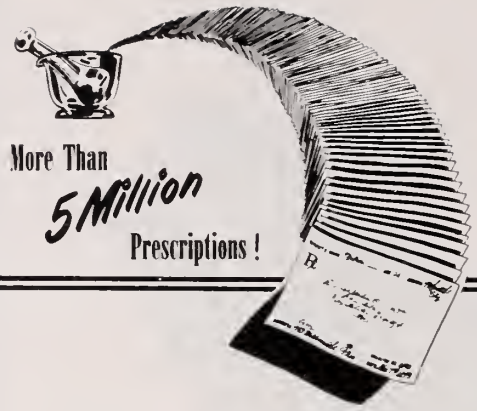
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"SWIMMER'S ITCH"

A Statement from the Rhode Island State Department of Health

FOR a number of years the State Department of Health has received sporadic reports during the summer months of a dermatitis appearing on persons after bathing in or shellfishing in the waters of Narragansett Bay. The department is attempting to determine whether this dermatitis is the same as that which appears on bathers at fresh water lakes in other parts of the country and is called "Swimmer's Itch." "Swimmer's Itch" has been found to be caused by a Schistosome larva released from infested fresh water snails and mussels. Some work has already been done locally in examining salt water snails for the presence of the parasite or its larva. In continuing this investigation, it is essential to know those areas of the bay where bathers or shellfishers have become affected. Accordingly, it will be greatly appreciated if physicians treating cases of dermatitis thought to have been caused by bathing or shellfishing in Narragansett Bay, immediately notify the State Department of Health (Jackson 1-7100, extension 235), giving the date of exposure, the probable locality where the disease was contracted, and those additional facts which are deemed pertinent to the case.

Olivier[1] describes the mode of invasion of the human skin and the sequence of events as follows, "The primary itching is a direct result of the penetration of the superficial layers of the skin by the entering larvae. This primary itching may last for an hour or more but usually subsides earlier. During this period a macule, about 1 to 2 millimeters in diameter, appears at the site of penetration of each cercaria. These macules are usually transitory but they may persist for several hours or until they are replaced by papules. Diffuse erythema may occur instead of the macular reaction and, rarely, an urticarial reaction may result at the site of penetration. Papules develop, along with intense itching (secondary itching), usually about 10 to 15 hours after penetration. The papules measure 3 to 5 millimeters in diameter and are distinct, indurated, and surrounded by a zone of erythema, the size of which depends, among other things, on the amount of rubbing or scratching induced by the pruritus. The area surrounding the papule may be edematous, especially after rubbing or scratching. When the papules are confluent, the whole exposed area may be elevated and edematous. On the second or third day, a vesicle forms on the papule and this is often ruptured by rubbing or scratching. The papules

usually recede and disappear within a week after exposure, leaving a pigmented area on the skin. The pruritus that accompanies the papular eruption is usually sporadic and intermittent and tends to disappear after several days. Excoriation may occur with severe itching. Pustules do not form unless the lesions become secondarily infected."

"Repeated exposures have produced succeedingly more severe reactions and have led the author to conclude that sensitization may occur."

Thorough drying of the skin, by rubbing with a rough towel, immediately after a probable exposure in contaminated waters, is the only prophylaxis which thus far has been offered. While this does not give positive protection against skin infestation, it will at least mitigate the number of lesions.

No specific treatment has been reported and these cases in the past have been dealt with symptomatically. The patient should be cautioned against scratching the lesions and secondarily infecting them. The intense itching has responded to calamine lotion and the antihistamine ointments.

[1] National Institute of Health (1949).

RHODE ISLAND DERMATOLOGICAL SOCIETY

On April 26, 1950, a group of Rhode Island dermatologists met at the home of Dr. Francesco Ronchese to organize a dermatological society for the purpose of the advancement of cultural and scientific studies of the diseases of the skin among physicians in the state of Rhode Island.

The group will operate under the name of "The Rhode Island Dermatological Society" and was chartered by Secretary of State Armand H. Cote on May 10, 1950.

The following officers were elected for one year:
President: Francesco Ronchese, M.D., of Providence
Secretary-Treasurer:
Bencel L. Schiff, M.D., of Pawtucket

Other incorporators are: Dr. William B. Cohen of Providence, Dr. Arthur B. Kern of Providence, Dr. Vincent J. Ryan of Providence, Dr. Carl S. Sawyer of Providence, and Dr. Malcolm Winkler of Providence.

Respectfully submitted,
BENCEL L. SCHIFF, M.D., *Secretary-Treasurer*

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The National Research Council recommends an increase in the minimum daily calcium intake for adults from eight-tenths of a gram to one gram.

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THE PROVIDENCE SURGICAL SOCIETY*

WILLIAM P. DAVIS, M.D., *President*

AT THE TIME of the founding of Jamestown, Virginia, in 1607 and of Plymouth, Massachusetts, in 1620, the Barber Surgeon represented the Medical Profession. Membership in the Royal College of Physicians was limited and there were extremely few medical degrees.

Those few physicians who had had Special Medical Training, fortunate enough to have trained in Edinburgh, Leyden, or under the Proctorship of John and William Hunter in England, and who dared the Rigors of the Colonies, rooted themselves in those cities which were the main ports of Entry to the New World—Boston, Philadelphia, Charlestown, or Newport, R. I. There were no Doctors with Roger Williams but in 1638 Dr. John Clark, who had studied both Theology and Medicine in Leyden, settled as Minister and Doctor in the Colonies in Locale' which one year later became Newport (1639). The First License issued in R. I. was in 1641 giving Dr. Robert Jeoffreys the right to "exercise the function of Chirurgera." It wasn't until 16 years later (1664) that the Court issued a license to Captayne John Cranston of Newport to practice both Physicke and Chirurgery. His was the First Medical License conferred in any of the Colonies.

Providence, a village of 1400 inhabitants in the year 1700, was without Physician or Surgeon, but medical attention was supplied by Dr. Richard Bowen of Seekonk, Massachusetts, (Now East Providence). By 1800 the population had risen to 7,614. The Rhode Island College, established at Warren, R. I., in 1764 had been moved to Providence in 1770 and was re-named Brown University in 1804. In 1811 Brown University established a Medical School which was to graduate 87 Doctors of Medicine before it became non-existent in 1828.

In part, due to the influence of Brown University Medical School, the first Organization of Doctors in the State of Rhode Island occurred in the year of 1812 when the First meeting of the Rhode Island Medical Society (49 charter Members) was held on April 22nd of that year. Seven other Medical Societies had preceded R. I.—N. J. 1766—Mass. 1781—Delaware 1789—New Hampshire 1791—Connecticut 1792—Maryland 1799—and New York 1807.

In 1848 the Providence Medical Society came into being just one year following the First Meeting of the American Medical Association at its convention in Philadelphia.

It was forty years later (1888) that Doctors George L. Collins, Clarence T. Godding, John W. Keefe, and Walter L. Munroe founded the Friday Night Club for the purpose of furthering Social Intercourse and Professional Advancement. Its meetings have been without interruption and it is still in existence, the oldest Professional Organization of its kind in R. I.

In about 1894, the Medical Science Club of Pawtucket was organized, limited to 15 members and meeting monthly. This club is still in existence.

In 1900 the Amos Throop Club was formed by Drs. Higgins, Fitzgerald, Jones, Fisher, Partridge, and DeWolf. Again for the purpose of Professional Advancement and Sociality, the Club existed without interruption until about 10 years ago. Several of its members were members of the Friday Night Club.

*Presented at the First Annual Meeting of the Providence Surgical Society, at Providence, R. I., April 27, 1950.

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ANNUAL MEETING

Providence Surgical Society

The first Annual Meeting of The Providence Surgical Society, was held at the Hope Club, Providence, Rhode Island, at 5:30 P. M., on April 27, 1950.

The objects of the Society are the cultivation and improvement of the Science and Art of Surgery and the consideration of such other matters as may properly come within its sphere.

The following officers were elected for one year:

William P. Davis, M.D., *President*
Frank E. McEvoy, M.D., *Vice President*
Eske Windsberg, M.D., *Treasurer*
Orland F. Smith, M.D., *Secretary*
Jesse P. Eddy, 3rd, M.D.
Robert H. Whitmarsh, M.D. } *Councillors*
Charles J. Ashworth, M.D.

An excellent dinner was enjoyed by forty (40) general surgeons, following which Arthur W. Allen, M.D. of Boston, Massachusetts, gave a very interesting talk on "Cancer of the Colon." Just before the delivery of his address, Dr. Allen was made the first Honorary Fellow.

The meeting adjourned at 9:45 P. M.

Respectfully submitted:
ORLAND F. SMITH, M.D., *Secretary*



"Stick-to-it-iveness is fine—



for everyone else...

"but take me—I just can't stick to my diet.
I can't resist desserts. Oh, dear, this diet is getting me down!"

If she thinks it's getting her down what's it doing to physicians who have to listen to such explanations every day? This is especially true for the doctor who hasn't prescribed Efroxine Hydrochloride.

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...It has a more rapid and longer-lasting effect with smaller dosage.

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Efroxine Hydrochloride *Tablets and Elixir*
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PROVIDENCE SURGICAL SOCIETY

concluded from page 312

The Medical Research Club was formed in 1910 by Drs. Utter, Calder, Sanborn, Leach, Adams, and Buxton. Its last meeting was held in 1920.

In 1922, the Malpighian Medical Society was founded by Dr. Raia, Ventrone, Conca, Oddo, and others among the Italian Physicians of the State. This organization has monthly meetings for the purpose of discussion of Scientific Papers and at the present time has a membership of 90.

The W. W. Keene Club was organized in 1923. Its regular Scientific meetings ceased during the war, but the club is still in existence, and its meetings are sporadic at the present time.

A small Dinner Club of Physicians came into being in 1928 and lasted until 1935. No name was given to this club, but I understand that it held regular meetings of Scientific nature. (Drs. Wing, Buffum, Utter, Lord, Adams).

Named for the Year in which it was formed, the Thirty-Four Club has continued its meetings and is active at the present time.

All of the above organizations were founded in much the same manner and for much the same purpose, that is for scientific discussion and for social relationship. In general meetings were held on a monthly basis and collation of some sort generally served. Membership embraced all branches of the Medical Profession.

In 1936, however, the Caduceus Club of Pawtucket made history in the State. Originally 18 physicians combined for the purpose of "Crystallizing opinion affecting the welfare of the club members and of the Community." Scientific papers were not to be read nor discussed. There are 52 members at the present time and meetings are held four times a year.

By 1950 Providence had in reality become a City. Its population, according to the last census, had risen to 253,504 and the Population of R. I. to 713,346. There are 1017 physicians in the State, 600 belonging to the Providence Medical Society and 794 to the R. I. Medical Association.

The Barber-Surgeon of 1607 passed into oblivion. Medical Diplomas became obligatory about the year 1850 and in 1884 a law was passed requiring Registration of all Physicians. It is interesting to note that the Physicians were responsible in part for a law having been passed in 1871, thirteen years previously, for the examination and registration of Pharmacists.

Although surgery was performed, it was performed by the general practitioner. Dr. John W. Keefe was, I believe, the first physician in Rhode Island to declare himself a specialist in Surgery.

We all are aware of the progress made since that time. Fostered and guided by the American College of Surgeons and the American Board of Surgery, we have added to the ranks of the Specialists in General Surgery here in Rhode Island to a point where we are able to gather here tonight 40 physicians who have dedicated their professional services to the general surgical needs of the inhabitants of the State.

For several years the need for a Society composed of surgeons ethical in professional deportment, qualified in professional skill, and confined to the practice of general surgery, has been recognized. Our hospital staff rooms were filled, on occasions, with discussions as to the merits of such a Society.

It remained for Dr. Orland F. Smith and Dr. Jesse P. Eddy to pave the way. At considerable expense to these two men in time, energy, and finance, the Chiefs of the Surgical Departments of the various hospitals in greater Providence were called in meeting at the Hope Club for the organization of a Surgical Society. Thus the Providence Surgical Society came into being and was incorporated under the State Laws, November 29, 1949.

We realize, for the first time, the difficulties encountered by the obstetrician. We hope that what tears we have accumulated in the process of delivering this Society into your hands may easily be sutured and with minimal scarring. Membership may be readjusted. Qualified surgeons unfortunately overlooked, or immature at the present time, will have ample opportunity for future consideration.

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A Major Advance in Peptic Ulcer Therapy:

Banthine*

BROMIDE

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AN ORIGINAL RESEARCH PRODUCT PROVIDING A NEW THERAPEUTIC APPROACH

ENCOURAGING results with Banthine in a group of refractory peptic ulcer patients were reported by Longino, Grimson, Chittum and Metcalf[1] and later in an enlarged series of patients by Grimson and Lyons[2]. Their observations interested other investigators[3-5] who have obtained equally promising results with this new drug.

These early observers[1,2] noticed that symptoms are sometimes relieved as soon as fifteen minutes following the institution of therapy, and in patients with long-standing, intractable pain discomfort becomes mild and intermittent or disappears. Their conclusions regarding healing of the ulcer are based on roentgenographic evidence.

Thorough pharmacologic investigations indicate that Banthine is a potent but safe drug in therapeutic doses. In these studies no abnormality of the blood or urine or other evidence of toxicity was observed.

BANTHĪNE: THE DRUG

Chemically, Banthine is β-diethylaminoethyl xanthene-9-carboxylate methobromide. Its generic name is methantheline bromide. It should be noted that the xanthene group bears no relation to the more familiar xanthine group of drugs.

A True Anticholinergic

Banthine may be described as a true anticholinergic drug. In therapeutic doses it controls autonomic stimuli which result in the vagotonia characteristic of the ulcer diathesis. This action is effected at

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the ganglions of both the sympathetic and parasympathetic systems and, in addition, at the postganglionic nerve endings of the parasympathetic system alone. Thus, the resulting therapeutic action is that of control of excessive parasympathetic stimuli effecting a consistent reduction of gastric hypermotility and, in most patients, a reduction in the hyperacidity which is commonly associated with peptic ulcer.

ADMINISTRATION

Because of the prominence of emotional or situational stresses in the ulcer patient and because these stresses vary in each patient, it is necessary to adjust Banthine dosage to meet individual requirements. Initial dosage may be 50 or 100 mg. (one or two tablets) every six hours, day and night, with subsequent adjustment to the patient's needs and tolerance. In addition, the usual adjunctive measures of diet, rest and relaxation should be prescribed for at least the first few weeks of treatment.

It is important that the usual high night secretions be controlled. To this end it is recommended that the night dose be taken six hours prior to the usual time of arising. Further, after the ulcer is healed, it is important that the patient be placed on a maintenance dosage schedule if he is to have a reasonable assurance of nonrecurrence. The maintenance dosage may well be approximately one-half the therapeutic dose and no evidence of chronic toxicity has been observed in maintenance dosage although this experience covers only a period of sixteen months.

Patients may report dryness of the mouth, mild degrees of blurring of vision, slight difficulty of urination or gastric fulness; these symptoms usually decrease or disappear on continued medication but if they are severe they may require dosage adjustment. Untoward reactions with Banthine therapy have not been encountered.

More complete suggestions for Banthine administration are available to the medical profession in Searle Reference Manual No. 40.

Banthine is a product of Searle research. G. D. Searle & Co., Chicago 80, Illinois.

REFERENCES

1. Longino, F. H.; Grimson, K. S.; Chittum, J. R., and Metcalf, B. H.: An Orally Effective Quaternary Amine, Banthine, Capable of Reducing Gastric Motility and Secretions, Gastroenterology 14:301 (Feb.) 1950.
2. Grimson, K. S., and Lyons, C. K.: Scientific Exhibit at the American Academy of General Practice, St. Louis, Feb. 20-23, 1950.
3. Grollman, A.: Pharmacology and Therapeutics, ed. 14, Philadelphia, Lea & Febiger, in press.
4. Dragstedt, L. R.: Personal communication, March 23, 1950.
5. Collins, E. N.: Personal communication, March 28, 1950.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

Meeting called to order by President Henry Brownell at 9:00 p. m. on March 28, 1950.

Capt. Griffin Bullwinkel, MC., USN presented a paper and showed movies relating to the medical problems of atomic radiation in wartime.

An application from Dr. Anthony Caputi for admission to this society was read and referred to the censors.

New application form for admission to county society was approved.

The old constitution and by-laws of the Newport County Medical Society which were presented in condensed form were rejected on motion of Dr. Samuel Adelson and sent back to committee for further study. Dr. Norbert Zielinski made a motion which was seconded that Dr. Adelson be appointed a committee of one to revise the by-laws. Dr. Brownell did not call a vote on this motion.

Dr. Adelson was requested by the president to seek legal advice concerning the problems of incorporating this society.

This society decided that at present there is no need in Newport for a committee on Hospitals and professional relations.

New member Dr. John Carey was welcomed to the society.

Meeting closed at 11:00 p. m. Collation followed.

Respectfully submitted,

M. Osmond Grimes, M.D.

BRISTOL COUNTY MEDICAL ASSOCIATION

The monthly meeting of the Bristol County Medical Association was held April 18, 1950 at 9:00 p. m. in the Rockwell House, Bristol, R. I.

A letter received by the President from the Warren District Nursing Association asking the medical profession to endorse the campaign for chest x-ray from May 9, to May 20, was read and approved.

The matter of Public Relations was discussed and the members present acted as a committee to inaugurate a rotating responsibility on the part of each doctor to answer emergency calls on Sunday and Holidays during the summer months. Each doctor is to have a definite date as to when he should answer calls if the family physician is not available. The list of those on call is to be posted so that each doctor may know his date in advance. Also the name of the doctor to be on call for each Sunday is to be published in the daily journal on Friday of each week.

Correspondence from the Judiciary Committee was discussed and endorsed.

At 10:00 p. m. the business meeting was adjourned and a scientific paper was presented by Dr. Frederick H. Stephens on Diseases of the Eye. Dr. Stephens considered in turn the following:

A.
1. Headache—caused by eyes or brain tumor.
2. Age factor on the type of conditions requiring eye attention. From childhood to old age.
3. Occupational eye diseases, strain, injuries.
4. Visual field examination in routine office work.

B. Children's eyes.
1. Vision of each eye tested by Snellen charts.
2. Hyperoplia and myopia.
3. Muscle balance and the difficulty it represents in children.

C. Social Problems.
1. Personality of individual as affected by the eyes.
2. Deficiencies and delays in the development of the opening of the naso-lacrymal duct.

D. Other diseases mentioned were conjunctivitis, sty, chalazion, iritis, glaucoma, diabetic retinitis, etc.

Slides were shown.

Respectfully submitted,

Arcadie Giura, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, May 1, 1950. The meeting was called to order by Vice President, Dr. Frank W. Dimmitt at 8:35 p. m.

The Secretary read the minutes of the previous meeting which were approved as read. The Secretary reported that at a recent meeting of the Executive Committee the following were among the actions taken:

continued on page 320



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As indicated in the table, Ovaltine in milk provides virtually all essential nutrients in balanced, generous amounts. Its protein is biologically complete. It supplies not only B complex vitamins, but also vitamins A and D as well as ascorbic acid and essential minerals.

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FAT	32 Gm.	VITAMIN B_1	1.16 mg.
CARBOHYDRATE	65 Gm.	RIBOFLAVIN	2.0 mg.
CALCIUM	1.12 Gm.	NIACIN	6.8 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN C	30.0 mg.
IRON	12 mg.	VITAMIN D	417 I.U.
COPPER	0.5 mg.	CALORIES	676

*Based on overage reported values for milk.

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

PROVIDENCE MEDICAL ASSOCIATION

continued from page 318

1. The Treasurer's report was accepted, and the Committee authorized the Treasurer to utilize Association funds as needed towards the cost of the installation of the heating system for the Medical Bureau, with the understanding that the Bureau will ultimately refund the money expended.
2. An appropriation of $150 was made to the Committee on Entertainment for use in connection with the annual dinner and golf tournament to be held in September.
3. The President was authorized to name a committee to consider revisions of the by-laws relative to Associate membership.
4. The President was authorized to appoint a Committee on Professional Relations and Hospitals, as requested by the State Society.
5. The President was authorized to appoint a committee of three as a Disaster Planning Committee to cooperate with a similar committee of the State Medical Society.

Dr. Dimmitt reported that a committee of Dr. Herbert C. Partridge and Dr. Elihu S. Wing had prepared the Association's tribute to the late Dr. Pearl Williams, and that the committee consisting of Dr. Francis V. Corrigan and Dr. Frank A. Merlino had prepared the Association's tribute to the late Dr. Alan E. O'Donnell, and these tributes will be placed on permanent file and a copy sent to the respective families.

The Secretary reported that the Executive Committee had revised applications for active membership in the Association and that it recommends the election of the following physicians:

John J. Bandeian, M.D.
Bertram H. Buxton, Jr., M.D.
Arthur J. Clarkin, M.D.
Calvin M. Gordon, M.D.
Louis E. Reik, M.D.
James J. Scanlan, M.D.
Maurice L. Silver, M.D.

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It was moved that the physicians nominated by the Executive Committee be elected to active membership. The motion was seconded and unanimously adopted.

Dr. Dimmitt called upon Dr. Charles L. Farrell, Chairman of the Committee on Public Policy and Relations of the Rhode Island Medical Society who spoke briefly on the work of his committee and displayed various media utilized in the public education campaign nationally and locally.

The first speaker of the evening was Dr. Charles E. Millard, of Warren, President, Rhode Island Academy of General Practice, who spoke on "Problems of the General Practitioner, and their Solutions."

Dr. Millard stated that the problem of restoring the family physician is a pressing one. The family physician is the greatest bulwark we have against socialized medicine. By elevating the status of these men we elevate the status of the profession as a whole.

Eighty per cent of the practice of medicine is in the hands of the general practitioners. His importance is therefore self evident, and we should do all in our power to improve the competence and capability of the general practitioner.

There are many factors that are depleting the general practitioner. 1. Medical schools and hospitals do not train general practitioners. 2. Hospitals are training men only for the specialty boards. Because of this there is very little inducement for the students to go into general practice because they cannot get hospital appointment.

The Board of Trustees of the American Medical Association in 1946 passed a resolution that hospitals be encouraged to establish general practitioner services and that hospital staff appointments should depend on the qualifications of the physicians and not on board certification. Practically the same resolution was passed by the Council on Hospitals.

Barring the general practitioner from hospitals decreases the inclination of men to do general practice, and also renders the general practice stagnant. As the specialties multiply and become more complex, there is an increased need for well-trained general practitioners who know the family background of the patient.

The only way to reverse this trend is to make better general practitioners. The objective of the American Academy of General Practice is to

1. Organize the general practitioner to maintain high standards.
2. Assist young men to practice general medicine.
3. Retain the right to practice in hospitals.
4. Assist in providing postgraduate course to general practitioners.

continued on page 323

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1. O'Keefe, E. S.: *Am. Jour. Dis. Child.*, 76:616, Dec., 1948.

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 320

5. Preserve the right of free choice of physicians.

This organization now has 15,000 members. To maintain membership, a member must put in 150 hours a year in postgraduate work of which 100 hours is composed of attendance at meetings.

There are now 837 hospitals in the United States that have general practice sections, over 60 institutions in the United States give general practice courses.

Dr. Dimmitt introduced the second speaker of the evening, Dr. Hannibal Hamlin, Assistant Surgeon, Department of Neurosurgery, Rhode Island Hospital, who spoke on "VASCULAR LESIONS OF THE BRAIN, AND THEIR SURGICAL TREATMENT."

Dr. Hamlin states that a large proportion by far of vascular lesions of the brain are non surgical conditions. Attempts to tap subcortical collections of blood should be reserved for patients under the 6th decade and good surgical risks. Bleeders occurs from a defective vessel.

In thrombosis of cerebral vessels, if stellgate ganglion block is used early, we may get improvement by stopping the concomitant spasm of vessels in that area.

Vascular tumors are amenable to removal. Angiomata, hemangiomata, including the cavernous type, and many of the gliomas have an enormous proliferation of vessels and bleed in their own substance.

In aneurysm of the Circle of Willis, the first symptom is bleeding. These patients are usually in the 2nd to 4th decade. Recurrence of hemorrhage is the rule. Many of the early attacks are diagnosed migraine since they bring on periorbital headaches. 8 per cent die in the first attack.

Arteriography is now a routine technique and is preferred to ventriculography. Arteriography of the internal carotid and carotid ligation is used in the treatment of this aneurysm. Either the internal or common carotid. Care must be taken not to reduce the pressure of the carotid to less than 50 per cent or thrombosis may occur.

He then showed numerous arteriograms with case histories. Some were treated by clipping vessels through a craniotomy wound. Some furthermore are being extirpated.

The meeting adjourned at 10:30 p. m.

Collation was served. Attendance 86.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

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WOMAN'S AUXILIARY
to the
RHODE ISLAND MEDICAL SOCIETY

Report of Annual Meeting, May 10, 1950

THE fourth Annual Luncheon Meeting of the Woman's Auxiliary to the R. I. Medical Society was held Wednesday, May 10, 1950 at 12:15 in Rumford at the Agawam Hunt Club. There were 148 members present.

The President, Mrs. William Newton Hughes, welcomed the members and guests.

Between courses of the luncheon the following people were introduced: Mrs. John S. Wheeler, President of the Woman's Auxiliary to the New Hampshire Medical Society, who spoke on the work they are doing in New Hampshire. Their special project has been to make a chart of health services available to the public.

Mrs. W. E. Wight, President of the Woman's Auxiliary to the Connecticut Medical Society, told of the special work they had done to increase the number of students enrolling in nursing. They had formed a speaker's bureau to review, for the students, the three nursing programs available in Connecticut.

Dr. Peter Pineo Chase, President of the R. I. Medical Society, brought greetings from the Medical Society and congratulations for the work that has been done this year by the Auxiliary.

Mrs. Hughes then presented the other guests at the head table: Mrs. Herbert E. Harris, first president; Mrs. Ralph L. Gilman, past president of the Woman's Auxiliary to the Connecticut Medical Society; Mrs. Peter Pineo Chase, wife of the President of the R. I. Medical Society; and Mrs. J. Murray Beardsley, past president. Mrs. John E. Farrell, wife of the Executive Secretary to the R. I. Medical Society, was introduced. Mrs. William P. Davis, Chairman of the Program Committee, and Mrs. Bertram H. Buxton, Chairman of the Hospitality Committee, were introduced and were given a rising vote of thanks for their work in planning the luncheon meeting today.

Our guest speaker, Mr. Thomas A. Hendricks, Secretary of the Council on Medical Service of the American Medical Association, spoke on the place of the Woman's Auxiliary in community leadership. First, he gave a test of 10 questions. In answering them, each member could gauge how much she was doing in the community as a citizen and voter and member of the Auxiliary.

He said that it was important to get into other organizations and encourage them to pass resolutions against government control.

He suggested that we sponsor a "National Community Health Inventory Day" with a general meeting of health organizations. This would show the people the services available to them.

A rising vote of thanks was given to Mr. Hendricks for his stimulating address.

Business Meeting

The President then called the fourth Annual business meeting to order.

The Secretary's report of the previous meeting was approved as read.

The Secretary's annual report was read. Mrs. James P. O'Brien moved that the report be accepted and placed on file. The motion was seconded by Mrs. Peter Pineo Chase. The motion was carried.

The Treasurer, Mrs. Stanley D. Davies, read the auditor's report carrying with it the Treasurer's annual report. The balance, as of April 30, 1950, was $1592.30. A motion was made by Mrs. Jesse P. Eddy and seconded by Mrs. John Walsh that the auditor's report carrying with it the Treasurer's report be accepted. The motion was carried.

The Vice President took the chair while the President read her annual report. Mrs. Hughes told of her activities during the year and of the National and State meetings she had attended. She expressed her appreciation for the help that had been given her. A motion was made by Mrs. Herbert E. Harris and seconded by Mrs. John Walsh that this report be accepted. The motion was carried.

Mrs. Joseph C. Johnston, Vice President, gave her annual report. A motion was made by Mrs. Henry T. Hanley and seconded by Mrs. Bertram H. Buxton that this report be accepted. The motion was carried.

A mimeographed copy of the reports of the Chairman of Standing Committees had been put at each member's place at the table before the luncheon. Mrs. Hughes announced that these re-

ports were read at the last Board meeting and it was recommended by the Board that they be accepted. A motion to accept them as a unit was made by Mrs. Robert M. Lord and seconded by Mrs. Francis H. Chafee. The motion was carried.

The report of the Nurses' Scholarship Committee was read by Mrs. Henry E. Utter, Chairman. The Secretary read the recommendation of the Board that the report be accepted. A motion was made to that effect by Mrs. Robert M. Lord and seconded by Mrs. William P. Davis. The motion was carried.

Mrs. James P. O'Brien acting Chairman, read the report of the Revisions Committee suggesting changes in the Constitution and By-Laws. The Secretary read the recommendation of the Board that the changes be accepted. Mrs. Herbert E. Harris moved that the following revisions be accepted:

Constitution

Article VI — General Officers

Section 2 — The Vice President, the President-Elect, the Secretary and the Treasurer shall be elected annually by the Convention and shall assume office at the close of the Convention at which they were elected and shall serve until the corresponding period of one year hence or until their successors are elected and installed, provided, however, that the President shall not serve for a longer period than one year except in case of an emergency so determined by the Advisory Council of this Auxiliary.

Here we have deleted the word President and added the words *President-Elect* since the President-Elect will automatically become President.

ADD

Section 2 (a) — The President-Elect on the expiration of her elective term as such shall serve as President for the succeeding term.

By-Laws

Chapter III — Duties of General Officers

ADD

Section 3 (a) — The President-Elect shall assume the duties of the Vice President in case of the latter's absence, shall attend all board meetings for one year and shall *automatically become* President at the next election.

Chapter IV — Standing Committee and Their Duties

Section 1 — Add 7. Hospitality Committee

ADD

Section 11 — The Hospitality Committee shall consist of a chairman and at least one member from each of the medical districts. The duties of this committee shall be to act as hostesses and to plan for a social hour at any given meeting and thereby increase friendly relations among the members.

continued on next page



Chapter VI — Component Auxiliaries

Section 4 — Each active member shall transmit to the Treasurer of this Auxiliary not later than February 28 annually, upon receipt of bill, dues amounting to $3.00 for the current year, which shall pay the member's assessment to this Auxiliary and to the Woman's Auxiliary to the American Medical Association. Where a district auxiliary is organized an additional assessment of $1.00 shall be made by this Auxiliary upon the members of such district auxiliary to be rebated to the Treasurer of the district auxiliary by the Treasurer of this Auxiliary. Here we have deleted the words "and shall also pay the member's annual subscription to the Bulletin of the Woman's Auxiliary to the American Medical Association." The reason for this is, there has been an increase in the cost of the Bulletin to $1.00. This along with an increase from 25¢ to $1.00 in dues to the Woman's Auxiliary of the American Medical Association would absorb two-thirds of the dues of each individual member. This would leave but one-third or $1.00 for our local organization which, of course, is insufficient. Therefore we have had to cancel the Bulletin subscriptions as a unit.

Chapter VII — Dues

ADD

Section 1 (a) — A person will be considered an active member in the organization for the ensuing year unless a written resignation is received by the Treasurer on or before February 15.

Section 4 — Between March 1 and March 15, the Treasurer shall transmit to the Treasurer of the Woman's Auxiliary to the American Medical Association, of which this Auxiliary is a constituent society, the dues required for each of its members for the coming year. We deleted the words "amount to 25¢." We used the word "required" rather than the present assessment of $1.00 since this amount may change from time to time.

The motion to accept these revisions was seconded by Mrs. Bertram H. Buxton. The motion was carried.

The President announced the Tellers. They passed out the ballots for the election of the Nominating Committee members and the Delegates to the American Medical Convention. They were as follows: Mrs. Herman Lawson, Chairman, Mrs. Robert T. Baldridge, Mrs. Kenneth Burton, Mrs. Ralph DiLeone, Mrs. Parker Mills, Mrs. Thomas Perry, Jr., and Mrs. Harold W. Williams. There was a recess for voting—the results of which will be announced in the Medical Journal.

Mrs. Lorenzo Emidy, Chairman of the Nominating Committee read the report of her committee suggesting the following slate of officers.

OFFICERS

President	Mrs. Charles L. Farrell
President-Elect	Mrs. Joseph C. Johnston
Vice President	Mrs. Henry S. Utter
Secretary	Mrs. Edward V. Famiglietti
Treasurer	Mrs. Stanley D. Davies

BOARD OF DIRECTORS

Providence	Mrs. Francis H. Chafee
Pawtucket	Mrs. J. Lincoln Turner
Newport	Mrs. Frank J. Logler
Kent	Mrs. Arthur Hardy
Bristol	Mrs. Charles E. Millard
Woonsocket	Mrs. H. Lorenzo Emidy
Washington	Mrs. William H. Tully, Jr.

Since there were no further nominations a motion was made by Mrs. Peter Pineo Chase and seconded by Mrs. J. Murray Beardsley that the nominations be closed and the Secretary cast one ballot to elect the slate of officers. The motion was carried.

The President, Mrs. William Newton Hughes, then thanked everyone for his help and cooperation and presented the gavel to Mrs. Charles E. Farrell. Mrs. Guy Wells proposed a rising vote of thanks to Mrs. Hughes for her splendid work as President this year.

Since there was no further business, a motion was made by Mrs. Henry E. Utter and seconded by Mrs. Francis H. Chafee that the meeting be adjourned. Respectfully submitted,

ISABELLE B. FAMIGLIETTI, *Secretary*

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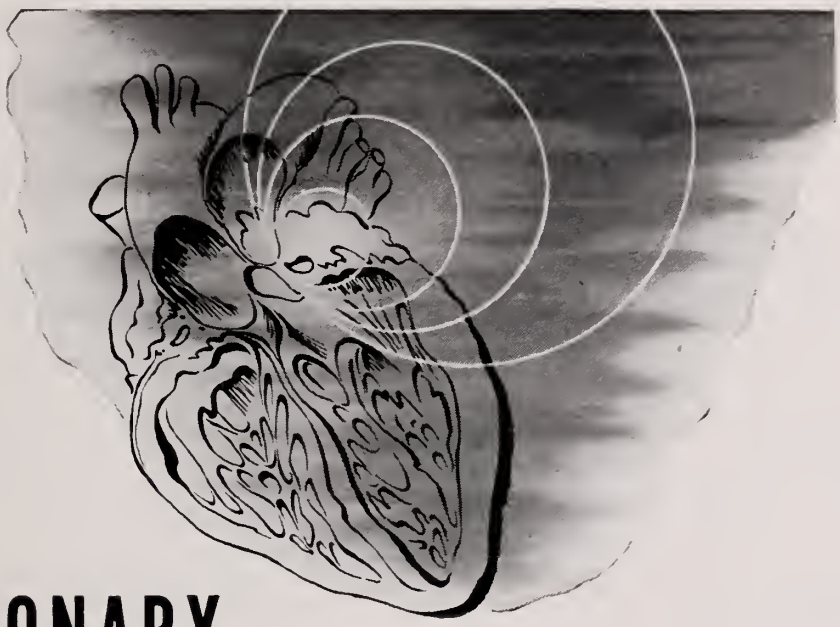
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CLOSED ALL DAY SATURDAY, and EVENINGS

RECENT ACCESSIONS TO THE LIBRARY

DAVENPORT COLLECTION

Merrill Moore—Clinical Sonnets, N. Y., 1949

William Carlos Williams—Paterson (Book Three) "The Library". N. Y., 1949

GENERAL COLLECTION

Lester F. Beck—Human Growth. N. Y., 1949

Charles H. Best and Norman B. Taylor—Physiological Basis of Medical Practice. 5th ed. Balt., 1950

Abraham Cantarow and Max Trumper—Clinical Biochemistry. 4th ed. Phil., 1949

Collected Reprints of the Department of Ophthalmology, West China University College of Medicine and Dentistry, 1938-1945. Gift of the University.

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, vols. IXA and IXB, 1948. N. Y., 1949. Gift of the Foundation.

Collected Reprints from the Wilmer Ophthalmological Institute of the Johns Hopkins University and Hospital, vol. IX, January 1948-June 1949. Balt., 1949. Gift of the Institute.

William Dock and I. Snapper, editors—Advances in Internal Medicine, vol. III, 1949. N. Y., 1949

Rene J. Dubos—Louis Pasteur. Bost., 1950. Gift of Doctor Peter Pineo Chase.

Jacob Fine—Care of the Surgical Patient. Phil., 1949

H. W. Florey and others—Antibiotics. 2 vols. Lond., 1949

Charles K. Friedberg—Diseases of the Heart. Phil., 1949

R. Max Goepp and Harrison F. Flippin—Medical State Board Questions and Answers. 8th ed. Phil., 1950

Benjamin L. Gordon—Medicine Throughout Antiquity. Phil., 1949

Maurice B. Gordon—Aesculapius Comes to the Colonies. Ventnor, N. J., 1949

Emil D. W. Hauser—Diseases of the Foot. 2nd ed. Phil., 1950

Frederick Hollick—The Male Generative Organs. N. Y., 1849. Gift of Doctor Louisa Paine Tingley.

Dorothy Ketcham—Michigan Hospital Handbook. Ann Arbor, 1940

Charles Mazer and S. Leon Israel—Diagnosis and Treatment of Menstrual Disorders and Sterility. 2nd ed. N. Y., 1947

Webster Merritt—A Century of Medicine in Jacksonville and Duval County. Gainesville, 1949. Gift of Mr. John E. Farrell.

Waldo E. Nelson, editor—Mitchell-Nelson Textbook of Pediatrics. 5th ed. Phil., 1950

L. H. Newburgh—Physiology of Heat Regulation and the Science of Clothing. Phil., 1949

I. H. Rubenstein—A Treatise on Contemporary Religious Jurisprudence. Chic., 1949. Gift of the Author.

Louis H. Sigler—Cardiovascular Disease. N. Y., 1949

Edward J. Stieglitz—Geriatric Medicine. 2nd ed. Phil., 1949

Edward Weiss and O. Spurgeon English—Psychosomatic Medicine. 2nd ed. Phil., 1949

Louis Wolff—Electrocardiography. Phil., 1950

Transactions of the Association of American Physicians, vol. 62, 1949. Gift of the Association.

The 1949 Year Book of Drug Therapy. Edited by Harry Beckman. Chic., 1950

The 1949 Year Book of General Surgery. Edited by Evarts A. Graham. Chic., 1949

GIFTS

Many gifts of books, journals and reprints were received. The following members contributed items: Doctors Beck, Burgess, Chase, Corrigan, Deery, DeWolf, Harvey, Kramer, Putnam, Joseph Smith, Thewlis and Tingley. Other gifts were presented by: Mr. John E. Farrell, Doctor Louis

Pomiansky, and Mrs. Eugenia A. Walsh (10 volumes of the American Journal of Nursing) and from the American Cancer Society, the Brown University Library, Peters House Library, the Providence Lying-In Hospital, the Providence Public Library, the G. D. Searle Company and the State Hospital for Mental Diseases. The State Hospital gave us 283 volumes of journals many of which were needed to fill in gaps in our runs of periodicals devoted to psychiatry and neurology.

BRISTOL COUNTY MEDICAL ASSOCIATION

At the May meeting of the Bristol County Medical Association held at the Martin Memorial Home, Warren on May 16, 1950, Dr. Wilson E. Hughes of Fall River discussed the subject of "NEWER MEDICINES IN PEDIATRICS."

His topic covered a wide range of remedies used in the treatment of children and infants. He spoke of clyses and its adjuvants, external applications, and internal administrations. He emphasized the value of each drug in its particular place, its optimum and its counter effect.

At the business meeting the subject of emergency calls for the summer season was again considered. Some associate members reported that they are not equipped to answer emergencies, so the men in Warren will cover the territory in the usual manner. Dr. Fletcher said that he would be glad to help, so his name appears on the holidays only. Dr. Leech has been cooperating by answering calls many times in the past. His name also appears on two of the holidays.

Primarily it is the duty of each doctor to answer to his own calls. If he is otherwise occupied, the doctor on call may help out.

The complete list of physicians who are to be on call is as follows:

	Bristol	*Warren and Barrington*	
May 30	Bruno	Creamer	Fletcher
June 4	Clark	Drew	
11	D'Angelo	Forget	
18	Holdsworth	Giura	
25	Serbst	Lewis	
July 2	Bruno	Millard	Leech
4	Clark	Petrucci	Fletcher
9	D'Angelo	Creamer	
16	Holdsworth	Drew	
23	Serbst	Forget	
30	Bruno	Giura	
Aug. 6	Clark	Lewis	
13	D'Angelo	Millard	
20	Holdsworth	Petrucci	
27	Serbst	Creamer	
Sept. 3	Bruno	Drew	Leech

Respectfully submitted,
ARCADIE GIURA, M.D., *Secretary*

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BOOK REVIEWS

PROCTOLOGY IN GENERAL PRACTICE. By J. Peerman Nesselrod. M.D., 276 pages with 64 illustrations. W. B. Saunders Company, Philadelphia, London, 1950. Price $6.00.

In reviewing this book, the first thing that is apparent to the reader is the experience and knowledge of the author, and his ability to convey the manner in which diagnostic and operative proctologic procedures can be accomplished in a simplified, yet thorough manner.

The book is divided into fifteen chapters and is packed with information of value to the busy practitioner and yet is concise. The author outlines accepted specific therapy and offers alternate measures when differences of medical opinion exist.

Deserving of special commendation is the author's enthusiasm in encouraging the use of the proctoscope in routine physical examination of the terminal bowel. His enthusiasm is paralleled with a word of caution on perforations of the bowel during this diagnostic procedure. He clearly enumerates seven diagnostic points of recognition of this serious yet avoidable accident.

Although the illustrations are excellent, understandingly I must express my disappointment that more colored, true to life illustrations were not included, since Doctor Nesselrod is a pioneer in proctoscopic photography and with Doctor Buie who presents the foreword to this volume, have an excellent library of colored photographic proctologic pathology.

For the general practitioner and the neophyte proctologist this is a valuable book. All in all, this book aids in a better understanding with a resultant better management of proctologic problems.

THAD. A. KROLICKI, M.D.

MEDICAL GYNECOLOGY. by James C. Janney, M.D., F.A.C.S. W. B. Saunders Company, Philadelphia, Pa. Second Edition, 1950. $6.50.

The second edition of this text follows the general scheme of the first edition but more space is accorded the use of the newer drugs and endocrine therapy. It is generously illustrated and very readable throughout its 432 pages.

The author divides this text into six general sections dealing with History and Physical Examination, Patient's Complaint, Physical Findings, Test and Special Examination, Gynecologic Treatments, and Socio-Medical Problems. Each chapter dealing with the patient's symptoms and the physical findings also includes a valuable table referable to the important factors in differential diagnosis.

As the title implies no effort is made to describe operative procedures, but considerable space is devoted to the management of office and out-patient problems.

The author also presents a very understanding and scientific approach to the psycho-sexual side of marriage and other controversial Socio-Medical problems.

In all, this volume represents a compilation of the author's gynecological lecture series, and is intended as a reference and review volume for general practitioners; however because of his concise method of presentation, and tables of differential diagnosis I believe that this text will also be important to the specialist in gynecology.

HENRY C. MCDUFF, JR., M.D.

CURRENT THERAPY—1950. Edited by Howard F. Conn and others. W. B. Saunders Co., Phil., 1950. $10.00.

Many aspects of current medical treatment change as rapidly as the New England weather. It is to the credit of Dr. Howard F. Conn and his two hundred fifty eminent contributors that they are abreast of these changes in their new text, "Current Therapy—1950", and that they have covered this changing subject completely, intelligently, concisely and clearly. This summary of current information on treatment of everything from absinthe poisoning to yellow fever accomplishes this mission without strain or pain to the inquiring reader. It is divided into fifteen sections covering all systems and types of diseases. Controversial subjects are discussed by two or more authorities usually from different medical centers in different parts of the country who represent different methods of approach in the treatment of the same disease—for instance, the treatment of the Common Cold is considered by Dr. Yale Kneeland, Jr. of Columbia University and Dr. Clayton G. Loosli of the University of Chicago. In this way the reader has the benefit of different experience and thinking on the one subject and can take his choice.

There is excellent coverage of new drugs and methods of treatment (such as the results of the surgical treatment of hypertension, written by Dr. Smithwick of Boston). Etamon, Dolophine, Dramamine, Eprolin, Pentaquin, Chloraquin and the various combinations of sulfonamide drugs are only a few of the new agents which are discussed with authority. Aureomycin and Chloromycetin (Chloramphenicol) receive due mention and are considered as authoritatively and as completely as is possible at this time considering their newness and our knowledge of their potentialities. The uses of Penicillin are now definite since this antibiotic is beginning to stand on its own two feet after some years of wide usage in many different diseases. One has the feeling that at last enough of it has been intelligently used so that now the authorities themselves feel secure in recommending the indications and the dosages. It will be ten more years before this situation comes to pass for the newer therapeutic molds, however, and anyone who goes to a textbook in 1950 for this information instead of to the new recent medical journals is foolish.

The composition, printing, paper and general plan of "Current Therapy—1950" are as modern as the text, and pleasing and efficient—a far cry from the dry and dull textbook arrangements of before World War II.

But after all, medical therapy is really the business of the practicing physician and not completely that of the teacher and scientist who is perhaps more concerned with diagnosis. Some day, perhaps, a volume of medical therapy will be written by busy general practitioners and specialists of many years' experience who are engaged in active practice in cooperation with the physicians in teaching and research. This would be the perfect text for it would contain the worth of factual knowledge and the charm and penetration of experience—reality of the test tube and the comfort of the bedside manner. Until that golden day this red hot and recent volume—"Current Therapy—1950"—will meet the need admirably and the yearly revisions will keep it up to date.

J. A. D

CHECK THE DATE - - -

WEDNESDAY, SEPTEMBER 6

GOLF TOURNAMENT and ANNUAL DINNER of the PROVIDENCE MEDICAL ASSOCIATION

(details later)

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Hewitt, W.L., and Williams, B., Jr.: New England J. Med. *242*:119, 1950

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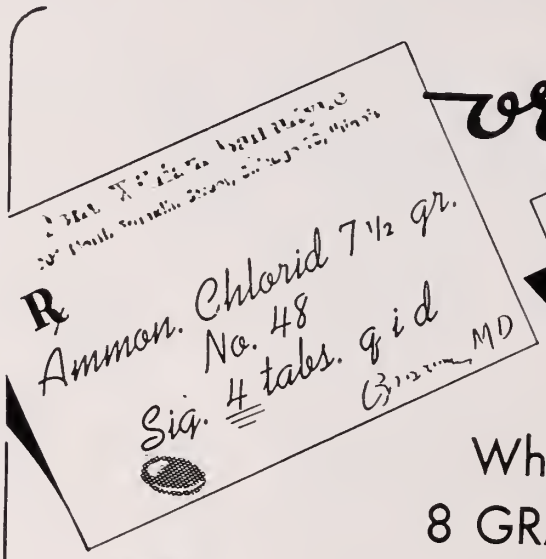
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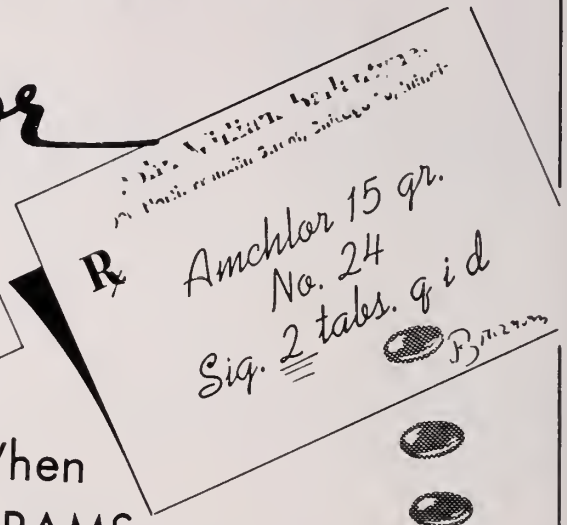
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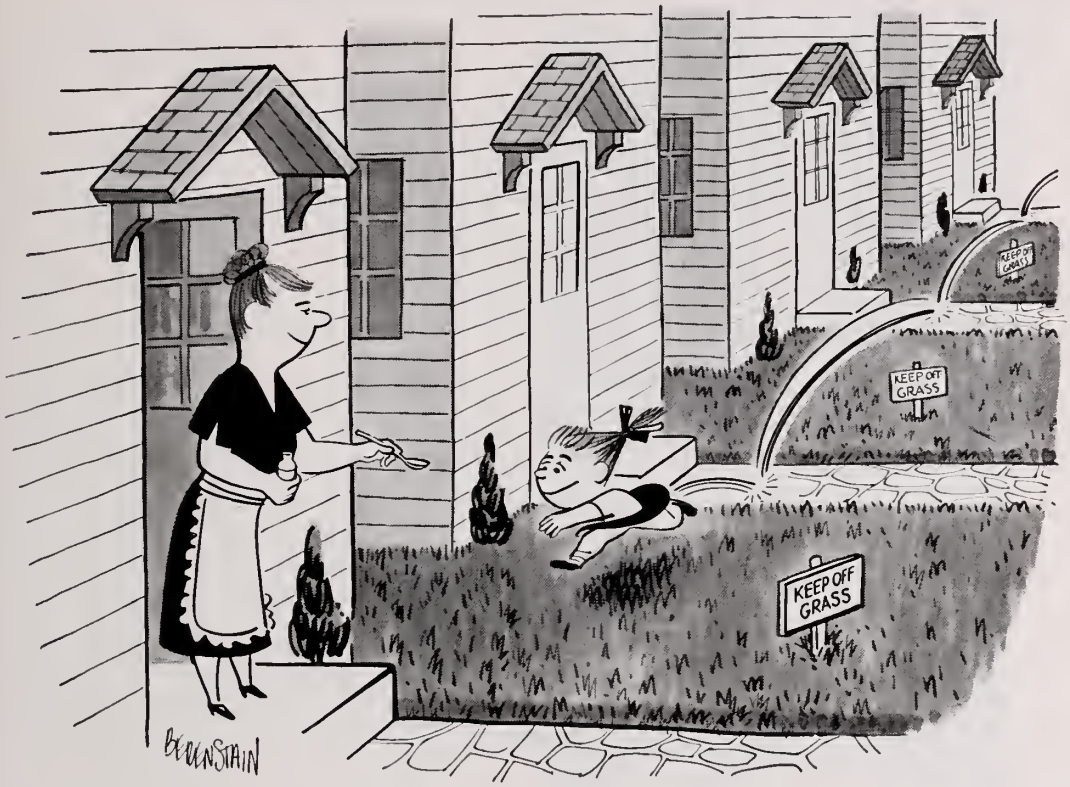
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*Orent-Keiles, E., and Hallman, L. F.: The Breakfast Meal in Relation to Blood-Sugar Values, Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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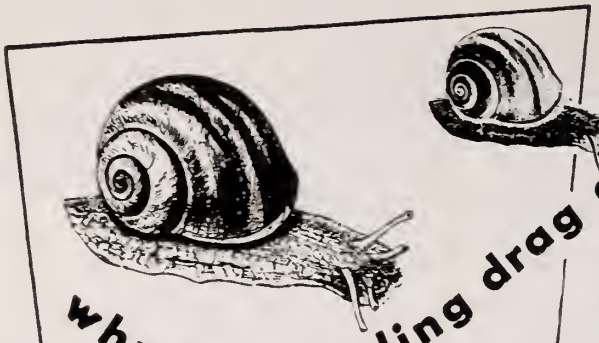
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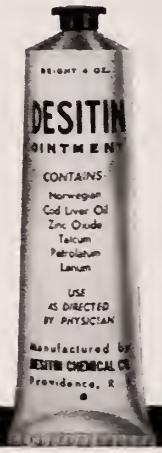
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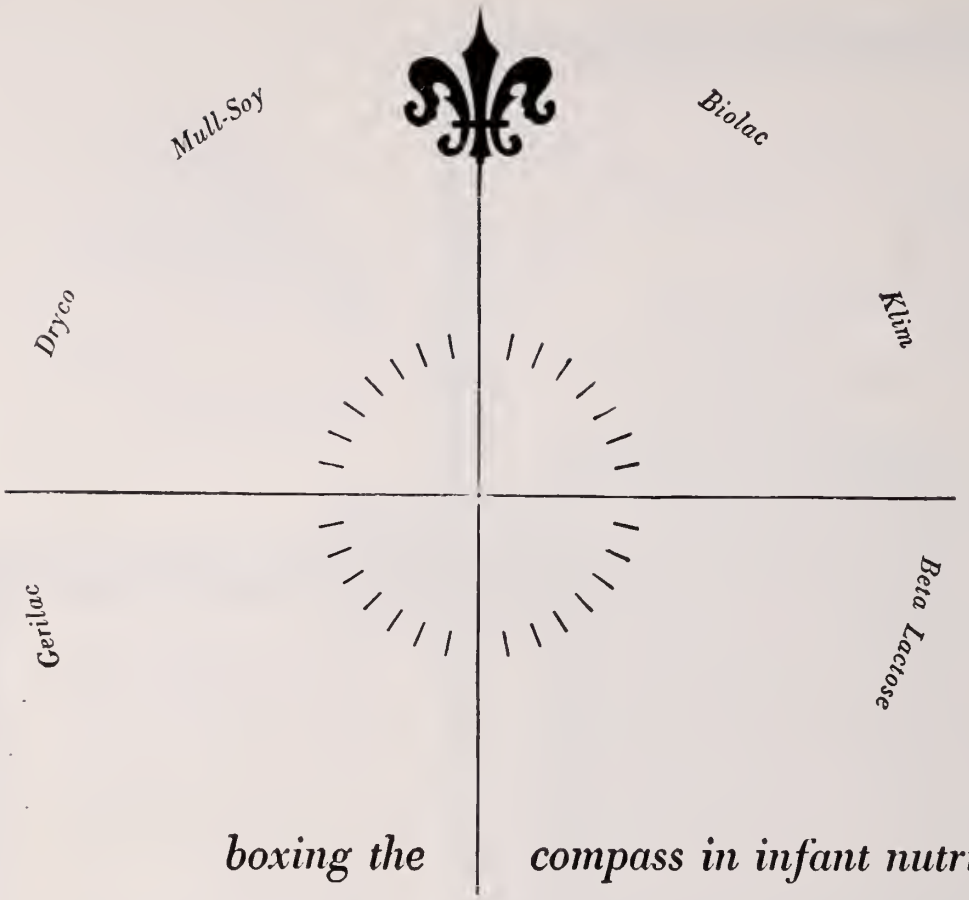
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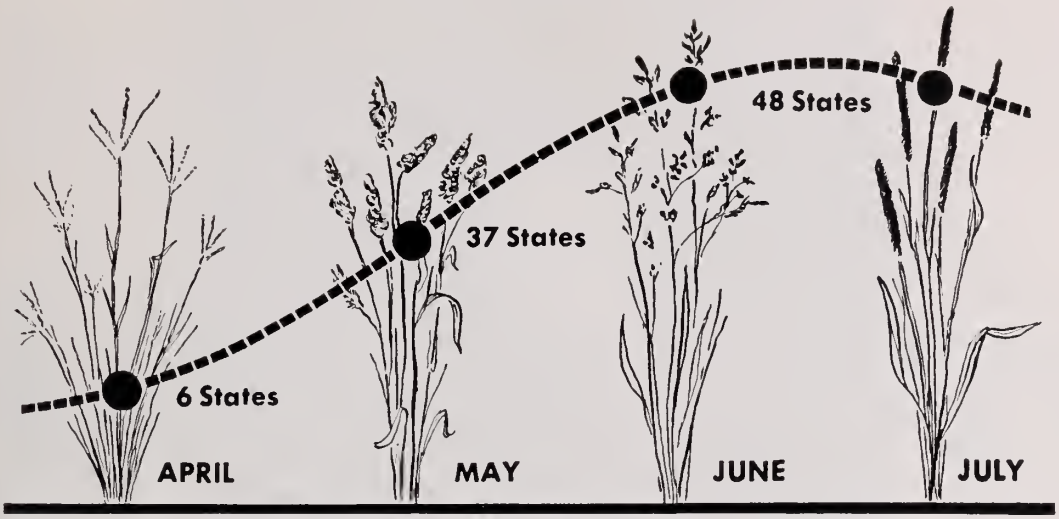
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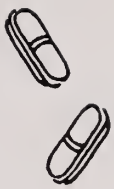
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[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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DIVERTICULITIS AND CANCER OF THE COLON*

JOHN J. MORTON, M.D.

The Author. *John J. Morton, M.D., of Rochester, N. Y. Professor of Surgery, University of Rochester School of Medicine and Dentistry.*

THE SURGEON is used to difficult decisions and usually makes them correctly after carefully weighing the evidence. However, he is confronted by a real dilemma which taxes his best judgment when the differential diagnosis lies between complicated diverticulitis and cancer. The usual uncomplicated diverticulitis with spasm is not hard to recognize. The usual cancer of the large intestine is equally easy to estimate.

The complications of diverticulitis consist of perforation with consequent abscess or peritonitis; the formation of adhesions about the leak, causing matting together of adjacent structures like omentum, small intestine, and bladder; the fixation of the area to the parietes; the development of bizarre sinuses and fistulae; the formation of multiple pus pockets in the wall of the sigmoid leading to fibrosis with narrowing to partial and even to complete obstruction of the large bowel; and the formation of a firm mass of tissue difficult to differentiate grossly from carcinoma.

In diverticulitis with perforation the patient is more ill than in the usual diverticulitis. His pain is more severe. It may radiate more widely toward the back, rectum, thigh, hip or penis. It is accompanied by nausea, vomiting and distention in most instances. The temperature tends to be more elevated and the pulse goes up with it. The white blood count rises to a higher range except in some of the very aged. Spasm is usual and a tender mass can be felt by abdominal, rectal or pelvic examination in most cases. Perforation into the general peritoneum is unusual fortunately, though with the antibiotics now available it would not be as serious as formerly. The vast majority of patients form a well localized abscess which may cause other symptoms such as bladder irritation, dysuria, increasing constipation or diarrhea, loss of weight, loss of strength and weakness.

Drainage of the abscess may lead to a fistula from the bowel to the skin. Failure to drain the abscess may allow it to burrow and to open by itself into another hollow viscus forming such fistulas between the bowel and urinary bladder, between the large and small intestine; into the urethra; rectum or vagina. Multiple openings may be present.

In case of repeated attacks of inflammation in the diverticula there may result thickening and scarring of the large bowel wall. This leads to a loss of elasticity, and narrowing of the lumen, going ultimately into partial or complete obstruction. This occurs with enough regularity to be recognized as one of the causes for large bowel obstruction.

The symptoms given by cancer of the colon have been stressed for a number of years so that they are well-known to members of the profession. The difference between the cancers on the right side of the colon and those on the left have been emphasized. The laboratory tests for blood in the stools; the importance of rectal examination; the value of sigmoidoscopic observation and biopsy; and the study of barium enemas with contrast air injections for accurate estimation of the state of the colon wall and lining, — have all been pointed out as necessary in the diagnosis of colonic cancer.

Perhaps it is not as well known that in some cases the growth extends through the colonic wall; and then, that an abscess forms; that occasionally also the omentum, small intestine and bladder become involved in such a case by adhering to the inflamed area; that the lesion becomes adherent to the parietes; that rarely there are fistulas between the colon, bladder and small intestines; that large bowel obstruction may be partial or complete; and finally, that the inflamed mass may cause fever, leucocytosis and a tender mass almost impossible to differentiate from complicated diverticulitis.

Cases of cancer with the above complications present problems in diagnosis to the physician, to the

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gynecologist, to the urologist, to the radiologist, to the pathologist, and to the surgeon. There is rarely complete agreement between them on any individual case. The pathologist, of course, has the final judgment when his microscopic sections are available. But he has been just as puzzled as any of the others when he has the same evidence as they, including the gross specimen.

It used to be taught that the presence of blood in the stools was an argument in favor of cancer as this event was of rare occurrence in diverticulitis. More recent studies have shown that the presence of blood in the stools is by no means unusual in cases of complicated diverticulitis and even 20% of simple diverticulitis with spasm may show blood at times. The discovery of blood is, however, an important finding. And the attending doctors should regard any such occurrences as indicative of malignancy till proved otherwise.

The physician finds himself responsible for a patient who gives a history of attacks of typical diverticulitis with spasm. Perhaps there have been barium studies in the past with clear demonstration of the diverticula in the sigmoid and the "picket fence" spasm above it. But on this occasion there is blood in the stools on repeated examinations. If he takes the initiative and treats his patient as he would the usual diverticulitis, he must be prepared to reverse himself if conditions indicate that he is not getting the proper prompt response. Continuation in the conservative course may jeopardize his patient's chances for surgical relief.

The gynecologist not infrequently sees a patient with a mass which is one with the left tube and ovary and may even push the uterus over. It may be tender and bulge in the cul de sac. The intestinal symptoms are minimal or minimized, so that barium enema studies are not even considered. The diagnosis is usually an ovarian tumor or cyst or it may be pelvic inflammation. When the exploration has been carried out and the sigmoid is found to be the offender, the surprise is great. In all suspected left-sided tumors of the tube and ovary, a simple fluoroscopic barium enema examination might save a lot of embarrassment later.

The urologist may be caught by these complicated diverticulitis cases. He is usually aware of the fistulas from the bowel to the bladder and gets the proper studies or consultations as indicated. When the diverticulum perforates into the extraperitoneal space near the bladder, gas crackles may develop in the area. He then thinks that he is dealing with an extravasation from the bladder or urethra.

The radiologist has a really difficult diagnosis to make when there is obstruction, partial or complete, at the recto-sigmoid. Often, the bowel is irritable and the patient cannot retain the barium enema. The radiologist is unable to get barium beyond the recto-sigmoid. It pinches off as a complete block. Or, he may get a little trickle by which gives a very confusing outline to the sigmoid lumen. He may not be able to see any diverticula at all; or he may interpret flecks of barium trapped in an ulcerated area as diverticula. Under these conditions the wise radiologist hedges. He says that he is unable to make a differential diagnosis between cancer and an inflammatory mass in these cases. He advises "repeat examination in a week or after medication." If blood has been demonstrated in the stools he says usually "that the evidence is in favor of carcinoma although inflammation cannot be ruled out."

When the pathologist is called upon to give his opinion of a gross specimen of complicated diverticulitis he is as uncertain as the surgeon. If he can open the specimen and see that the mucosa is intact, it is usually safe to call the lesion benign. But, not always. Some infiltrating carcinomas are deceptive and show no demonstrable breaks in the mucosa. When the surgeon has to leave the gross specimen in situ the pathologist judges by the appearance of inflammation in the area. Often a biopsy is taken from the nearby structures which seems to be surely neoplastic, only to have "inflammatory tissue" or "hyperplasia" returned from the frozen section study. The pathologist, as in every other situation, has the final word.

The real burden of responsibility falls on the surgeon. The medical man and the radiologist do not hesitate to press for an answer in a doubtful case. They urge the surgeon to explore and to establish the diagnosis. If the surgeon feels a little hesitant and believes that the patient should be treated conservatively they agree but feel relieved that the burden has been shifted. Before the antibiotic era, exploration was a considerable hazard in these complicated cases. The infection could be stirred up and generalized by the trauma of resection or by simple palpation. The anastomosis in an infected zone might fail to unite properly with a resulting necrosis and a new abscess or a fistula. But we can now disregard these dangers to a large extent by proper selection of the correct antibiotic before and after the operation. Every patient who has a mass and who has bleeding from the bowel is a proper candidate for exploration. Even with the lesion in his hand the surgeon has only a 50-50 chance to make the right diagnosis. In every case it is safer to proceed as if the diagnosis is surely cancer. And to be pleasantly surprised when it turns out to be inflammatory only.

The coexistence of diverticulosis or diverticulitis and cancer in the sigmoid colon is considered quite rare. Oren reported on two such cases in 102 cases of diverticulosis. He quoted the other writers noted below. Fallon had only 3 cancers in 625 cases of diverticulitis and in 1800 cases of diverticulosis.

In 1600 operations for cancer of the colon only 19 had diverticula in the same area. Rankin and Brown found cancer in only 4 of 227 cases of diverticulitis and in all their cancer operations diverticula were present in only 4. Tom Jones reported the two lesions together in 3 of 300 cases. Arnheim reviewed the 10 year period of diverticulitis cases admitted to the Mount Sinai Hospital. There were 35 cases. In only one case was there an associated carcinoma.

There is no evidence that diverticulitis is a precursor to cancer. The fact that the two lesions may coexist is easily accounted for. According to Karsner diverticulosis of the large intestine is present in 25%-30% of all adults. The sigmoid is the segment of predilection for this condition. It is generally conceded that 25% of all the colon cancers occur in the sigmoid. The probability of the two conditions existing together is therefore to be expected.

There have been 13 cases of coexistence of the two lesions in the sigmoid in the University of Rochester hospitals. There have been 10 additional cases of carcinoma elsewhere in the colon with diverticulosis or diverticulitis in the sigmoid. When these cancers are in the rectum or at the recto-sigmoid their diagnosis is usually possible. The cancers at the cecum, transverse colon and at the flexures may or may not be so easily picked up especially if there is marked spasm in the sigmoid above the diverticula or an abscess which further complicates the picture. These complications may completely mask the cancer for a considerable period.

There have been 17 additional cases of partial or complete obstruction at the sigmoid or recto-sigmoid junction. Many of these have had other complications such as abscess and fistula. The diagnosis in this group has been exceedingly difficult and has tested the resources of all concerned. These 17 cases have been considered to be complicated diverticulitis as no cancer has been demonstrated in any of them. They have all shown diverticula by x-ray examination. Abscesses have been drained in quite a number and their subsequent course has been proof of infection alone.

Tissue which appears likely to help establish the diagnosis should be secured for microscopic examination if possible. It is well to remember that a negative report for carcinoma, however, does not mean that there is surely none present. It may simply represent an unfortunate selection of tissue. Sometimes as many as 3 or 4 biopsies have failed to show cancer and yet it was present deeply imbedded in the inflammatory mass. The lymph nodes removed for diagnostic purposes have usually turned out to be hyperplastic.

The history of blood in the stools or tarry stools always calls for the most careful scrutiny to determine its source. In the 13 cases which proved to be cancer, blood in the stools was demonstrated in 10 of them. The other 3 cases gave no history of it and it could not be demonstrated by stool examination. In the 17 cases which turned out to be diverticulitis with complications blood was found in the stools only 6 times. The failure to get a history of bloody stools and the inability to prove it by clinical test would make one lean more toward the diagnosis of an inflammatory lesion.

In no other respects were the history or physical examinations of differential diagnostic value. The patients all showed evidence of a severe disease of some kind. The proof rested finally on microscopic section. In some doubtful cases the ultimate diagnosis was not proved. These have not been included in this study. Other cases which were thought to be a combination of cancer and diverticulitis have turned out to be cancer alone. These have been set aside also.

Proctoscopic or sigmoidoscopic examination in both groups of cases is indicated. It may serve to define the cause for bleeding in some cases. Hemorrhoids, fissures or polyps low in the rectum will be recognized. Occasionally, a biopsy can be secured which will allow the diagnosis of cancer. The presence of pus and blood is seen also but this may mean infection only and should not be stressed as a diagnostic point.

Many patients with marked spasm or with obstruction cannot retain the barium and the barium enema study fails because of this. In some instances it has been possible to make a diagnosis of cancer by putting barium into the distal loop of a colostomy and having it outline the lesion in the sigmoid. The x-ray differential diagnosis between cancer and diverticulitis is based on the following points. In diverticulitis there is associated picket-fence spasm above the area often for a considerable distance; there is absence of distention of the large bowel above the diverticula; there is a relatively longer segment of intestine involved; and diverticula can be demonstrated, often retaining barium in them a long time after examination. The area is usually tender on palpation. The bowel is more distensible. After a period of medical treatment the improvement may be marked giving an entirely different picture when the spasm has relaxed. In carcinoma there is a nodular filling defect or a napkin-ring construction about the bowel. It is usually not sensitive on palpation. It is rigid and non-distensible; it is firm but not fixed. In complicated cases of cancer or diverticulitis all these criteria fall down and merge into each other. This is one of the reasons for the difficulty in diagnosis.

The treatment should be pushed in all doubtful cases. It is fair to give a reasonable medical trial

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INDUSTRIAL MEDICINE AND THE PRIVATE PRACTITIONER*

JOHN J. POUTAS, M.D.

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IT WAS with real enthusiasm that I accepted the invitation to speak to this group of physicians on some of the broader aspects of industrial medicine, emphasizing its objectives and procedures and the essential role played by the Private Practitioner of Medicine.

As you will gather from the title, I will not concern myself with details of diagnosis and treatment.

It is a rash individual who appears before a group of physicians at a professional meeting and expects to hold their interest with a subject non-clinical in nature. I am, however, convinced that what I have to say has a practical application for each of you.

In order that you may have a proper background for my remarks, I will list briefly the objectives of a modern progressive industrial medical program as follows:

1. To select personnel physically able to do the work expected of them with no hazard to their health and safety or to the health and safety of their fellow employees.
2. To provide prompt medical care for industrial accidents and injuries.
3. To assist in the maintenance of a sanitary working environment free from industrial health hazards.
4. To apply preventive medicine techniques including health education and health counseling.
5. To provide sufficient medical care for non-industrial illness, including medication to render the employee relief and comfort, if it is decided that he should stay on the job.
6. To advise and assist the employee in obtaining prompt medical care for non-industrial illness or accident from his personal physician when such is indicated.
7. To work with Management in every practical manner to insure minimal absentee rates and minimal duration of absenteeism from illness and accidents.
8. To cooperate with, but not to replace, the private practitioner of medicine and the official and non-official health agencies of the community.
9. To comply with the Workmen's Compensation provisions and industrial hygiene codes of the respective states.
10. To work closely with those charged with safety practices.
11. To cooperate with Medical Schools, Schools of Public Health, and Schools of Nursing in their educational and training programs in the field of Industrial Medicine.
12. To carry out pertinent research.
13. To maintain the highest professional standards in the attainment of the foregoing objectives.

It is my belief, for purposes of this discussion, that the term "industrial medicine" can be somewhat of a misnomer. I say this inasmuch as it implies a specialty, distinct and separate from private practice. I do not say that specialized interest, training and knowledge are not essential for the physicians in industry. I do mean, however, that there would be no industrial medicine in this country without the private practitioner. He has made it the effective weapon it is today, and has developed it along with his practice. Industrial medicine is closely woven into the general pattern of medical practice in this country. Actually thousands of physicians have part-time industrial medical appointments.

There is a definite tendency and a real need for industry to develop full time medical departments. The bulk of the problem will, however, continue to fall upon the shoulders of the private practitioner. Even in those industries where medical departments have been established, many of the services are rendered on a part-time basis. It is well recognized too that the major problem in industrial health today is the problem of the small plant where no medical services whatever are provided. This deficiency will probably be filled by part-time physicians, although full time service by one physician to a group of small plants is a promising and progressive procedure.

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Even in those industries where you find a well-equipped and well-staffed medical department, with a good program, there are very few, if any, which go beyond the diagnosis of conditions in the ambulatory employee and health counseling. Referrals are then made to the personal physician. I do not have reference here to the industrial accident case, which may account for but a small proportion of industrial clinic visits. This proportion of course varies with the nature of the industry. The heavier the industry, as a rule, the higher the proportion of visits for industrial accidents of total clinic visits.

Importance of Industrial Programs

Why do industries have medical programs? The reason is obvious: to insure a healthy, safe, happy, efficient employee population *per se* and in the interest of economy. Several states have already adopted laws which make it mandatory upon management to provide certain benefits for the individual who is ill for non-industrial reasons. Most absenteeism in industry is due to non-industrial personal health problems. It is, therefore, important for management to invest in preventive medicine. In those industries where the industrial accident load is not heavy most of the clinic visits are for personal health reasons. In many such cases, however, the employee would not have consulted his private physician. This does not mean that the visits were not justified. Nor does it mean that such visits are not a challenge to the industrial physician and nurse. The employee had some complaint, however vague, some problem, and took it to the physician or nurse for guidance at a stage when he probably would not have sought advice were the services not readily and freely available. The industrial physician and nurse must be constantly aware of the opportunity this presents to sense trouble at that very early stage, so favorable for effective action.

All procedures in the industrial clinic are carried out at a high professional level and in a confidential manner. The union, employees, management and medical profession must be completely informed as to the objectives and program of the medical department. They must realize that industrial medical departments are more than first-aid stations.

It is well appreciated by all of us that, equipped though we are with miracle drugs and miracle skills, an important cause of death and disability continues to be the lag between the development of symptoms and the institution of treatment. We in industrial medicine are in a position to do something about this very tangible problem.

The Role of the Physician

I will now discuss in some detail certain aspects of an industrial medical program emphasizing the important role played by the private practitioner. By this designation "private practitioner" I include both the general practitioner and the specialist.

The first duty of an industrial medical service and, indeed, the duty which resulted in its creation, is the provision of medical care for industrial accidents. This problem varies widely in accordance with State laws, personnel, and equipment available. Some of our larger heavy industrial plants have full-time medical departments and well-equipped hospitals on the premises. They carry out complete diagnosis and treatment. Frequently, however, industry provides the initial care for a major accident and the case is then referred to an outside source for further diagnosis and treatment.

I would like to digress at this point to emphasize that the industrial physician who approaches each problem with interest and imagination never finds his work lacking in stimulation. It is occasionally said that the industrial physician who must refer many of his problems, will invariably lose his interest and skill. I do not concur in this belief.

Certain states have provisions in their Workmen's Compensation Law which provides that even though physicians are available on the premises for first aid and continued treatment, the employee has the right of free choice of outside physicians. This further emphasizes the close association, in fact the inseparability, of industrial medicine from the private practice of medicine.

Another facet of the industrial medical program is the provision of pre-placement physical examinations. Certainly industry has the privilege and even the duty of ascertaining before employment that the individual is actually capable of doing well and safely the job for which he may be hired. The pre-placement physical examination is *not* undertaken to eliminate from employment all but the physically perfect. In many cases these pre-placement examinations are accomplished by full or part-time physicians on the premises, but in many instances they are done on a fee basis on the outside by outside physicians.

It is necessary when doing these examinations to keep in mind the objective of the examination, namely, the selection of a safe, healthy efficient employee. The physician should know and keep in mind the physical demands of the job. If it is a travelling salesman position, for example, it should be remembered that a salesman may spend long, weary hours driving under all road conditions and may or may not be expected to carry heavy loads.

In most industries there is a broad classification of potential employees into one of four basic groups:

Group 1 Those physically acceptable immediately for all types of employment.

Group 2 Those physically acceptable but only for certain types of employment.

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Group 3 Those rejected pending correction of defects.

Group 4 Those rejected and in which no further action is indicated.

An alert, progressive Medical Department keeps its Group 4 (absolute rejections) percentage to a minimum. Industry should provide opportunity for the disabled to earn a livelihood, and the disabled frequently make excellent employees. There is a distinct contribution in a pre-placement examination if one bears in mind that those with remediable defects in Groups 2 and 3, of whom there are many, often thank this procedure for resultant definite improvement in their physical well-being.

Pre-Placement Examinations

The pre-placement examination should not be a routine asking of questions and a cursory examination. It is the forerunner of and typifies what is being developed today outside of industry: I have reference to the periodic health examination. In most cases a complete physical examination, including history, is given, taking approximately 30-45 minutes. Most industries require chest x-rays and blood tests. If by any chance you do pre-placement work for an industry, make it a real, worthwhile procedure of value alike to management and employee, and not a mere matter of form.

Individuals classified as Group 2 or 3 are, of course, referred to their personal physician for correction of defects at their own expense. Your response should be and most frequently is cooperative and helpful.

Such a response is possible, however, only if the objectives and scope of the examination are sincerely understood and appreciated. In this connection it is revealing how many individuals have no personal physician, or, if they have one, have not visited him for years. The practice of pre-placement physical examinations in industry often stimulates the selection and utilization of a private physician on the part of the employee.

Only recently, we had occasion to do a pre-placement physical on a girl with unusual secretarial training and experience. She was applying for a position of considerable importance. Several weeks had been consumed in finding this person. It would also require several months on-the-job training to bring out her top performance.

Her immediate past health history was negative, as was her absentee record with her previous employer. In other words, failure to have a pre-placement physical would have resulted in her rheumatic heart condition being overlooked. She had rheumatic fever at 14 and had not been to a physician since that time. Upon physical examination she showed definite evidence of an enlarged heart and cardiac arhythmia, confirmed by x-ray, fluoroscopy and electrocardiography.

A cardiac consultant advised that without preventive therapy she would probably decompensate within one year, but that on a proper regime she would be a good risk.

The young lady was employed provided she placed herself under the care of her personal physician.

Thus a distinct service was done in the pre-placement physical both for management and the employee. I will add what many of you might suspect, selling the young lady on the idea was a most difficult and trying experience.

Periodic Health Examinations

Many industrial medical programs, and the number is increasing, provide for periodic health examinations for entire groups or for certain selected groups. These periodic health examinations are in some instances carried out on a contract basis by outside physicians. In other cases they are performed by full time personnel. In most cases they include chest plate and electrocardiograph, although in many instances history and physical alone are provided. Participation usually is voluntary and results are strictly confidential. As a rule no treatment is provided. Copies of the findings may usually be sent to the individual's personal physician upon request of the employee. Here again the closest possible cooperation between the private practitioner and the medical department of the industry is absolutely essential. The private practitioner to whom these cases may be referred for more definitive examination, or for correction of defects, must have a keen and complete appreciation of the periodic physical examination. He must not have the attitude occasionally found that such are a waste of time.

The problem of periodic physical examinations can become so tremendous that many industries, in order to do a more complete and efficient examination, limit these services to executive groups, to those exposed to possible industrial hazards, individuals with poor accident records and those with poor health and efficiency records.

The usual policy followed in cases of clinic visits for personal health reasons is to provide medication to make the employee more comfortable, if he is to remain at work, or to suffice in any event until he can see his personal physician.

It cannot be over-emphasized that the industrial medical department in no way attempts to replace the private practitioner of medicine. It supplements his work but it never replaces him. Due care is taken when treatment is given and the person referred to a physician, that the treatment given is not of such a nature as to interfere with subsequent diagnosis. In providing this initial diagnosis and referral to the private practitioner, there can be no doubt that a tremendous opportunity presents itself.

Many of these individuals might have delayed consulting a physician for weeks or months. Here is the closest possible effective relationship between the private practitioner and the physician in industry. The one does not take the place of the other, but makes the other more effective.

It is routine procedure in most industries for individuals who have been out ill for one reason or another to return to work only with the approval of the medical department. In many instances clearance by the personal physician is demanded in illness involving several days' absence. Here again close cooperation between physicians is necessary and should result in minimal absentee rates and duration of absence.

Health Education Lags

The possibilities of health education and health counseling techniques as part of industrial medicine have not been fully developed. It is a rare clinic visit which cannot be used as an entering wedge for good sound health counseling such as you all do in your office. The preparation of articles for the industrial house organ, usually in cooperation with national health education drives, which are almost monthly, can contribute materially to positive employee health.

A most important part of any industrial medical program is the anticipation, recognition, prevention and control of industrial hazards. The physician who is engaged part time in industry must be personally acquainted with every part of the plant and operation which he serves; he must visit all parts of the plant at frequent intervals; he must be familiar with the materials used, with the methods used, with their toxic and hazardous potentialities. He must be informed of and aware of new processes and procedures which might involve hazards not present up to that time.

The private practitioner seeing an employee on the outside must keep in mind the possible industrial implications of any complaint. If indicated, he should communicate with the plant physician concerned for a mutually beneficial exchange of information.

The nurse plays a major role in any industrial medical program. Many industries provide no service other than that offered by a nurse. In many instances where part or full time medical personnel is available, the nurse screens out those employees whom she judges should see the physician. In these decisions she is expected to be capable of independent professional judgment and should be acting in accordance with the written standing orders of a physician supervisor. The physician in industry should take the time to discuss interesting and important cases with his nurse. Only in this way will she be able to provide him and the employee with the necessary and important follow-up service.

Industrial medicine affords a splendid opportunity for medical research. We are dealing with a self-contained group which is, on the average, more amenable to our efforts than the general population. Our files are filled with epidemiological data as to the behavior of disease.

It is my earnest hope that industrial medicine will continue to develop as part of the pattern of the general practice of medicine with emphasis placed on perfection. Development of all possible cooperation between the industrial and the personal physician and complete enjoyment by industry and medicine of the mutual benefits springing from close association in teaching and research, are much to be desired.

DIVERTICULITIS AND CANCER OF THE COLON

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in the hope of a prompt recovery. The usual medical treatment is employed. Rest, low residue diet, antispasmodics and antibiotics are the customary treatment. Some clinics use local careful irrigations and others avoid them. The fever and leucocytosis should subside within a few days. Tender masses may get smaller and less sensitive. If this does not occur, drainage of abscesses may be indicated. After this has been done recovery should be prompt in diverticulitis cases but if it does not take place more drastic measures must be taken. Surgery should be radical as if for cancer, taking parts of whatever organs or tissues are adherent to the growth and repairing the defects afterwards. These operations are by no means simple. Sometimes two or three loops of small intestine and a portion of the urinary bladder will be involved in the mass. To separate them will be fatal if there is cancer spreading through these tissues. Consequently in some cases tissues will be removed for inflammation only but this is a risk that must be balanced against that of spreading a possible cancer.

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THE PROBLEMS OF GENERAL PRACTICE AND THEIR SOLUTIONS*

CHARLES E. MILLARD, M.D.

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OF ALL the manifold problems besetting the medical profession at this time, that of restoring the family physician to a position commensurate with his contribution to society appears to be one of the most pressing. Unless this problem is solved to his advantage, all of medicine will come crashing from its lofty pinnacle. The family physician is the basic unit of the medical system and is the profession's greatest bulwark against socialized medicine.

Sir William Osler said: "The public bases its estimate of the medical profession on its opinion of the family physician, who is the yardstick by which all medical care is measured. By elevating the status and dignity of the family physician, we elevate the status and dignity of American medicine as a whole."

More recently, Dr. Kirkland, Secretary of Advisory Board of Medical Specialties said that the general practitioner is indispensable to the public and is the basic unit of the medical profession, which cannot be denied. As a matter of self interest, if for no other reason, all other groups in the profession should vigorously defend him from exploitation and assist him in securing his rights and proper dignity.

When one considers the fact that approximately 80 percent of the practice of medicine is in the hands of the general practitioner, and that upon his decisions depends the life, health and welfare of such a large majority of our people, his importance is immediately self-evident. It should, therefore, behoove the medical profession to do everything within its power to make these men as competent and as well-trained as is humanly possible.

However, in the past two decades, diametrically the opposite view has become prevalent. As you are all well aware, there has been tremendous emphasis placed on specialization while de-emphasizing general practice. This is clearly demonstrable by the following:

While our population has increased about 12 percent, our physician population has increased 14 percent. However, because of the large number of our younger men entering the specialist fields, the general practice population has decreased. In 1949 there were approximately 199,775 active practicing physicians in the United States, and of this number 42,000 were specialists, 29,000 Board certified, and 13,000 listed themselves as part time specialists.[1] In 1941 there were a little over 5,000 residencies whereas in 1949 there were over 15,000 residencies.

There are many factors operating to deplete the number of men entering general practice, and chief among these are:

1. The failure of our medical schools and hospitals to provide adequate training facilities for men desirous of entering general practice.
2. The tendency of hospitals to approve for staff appointments only those men certified by the specialty boards. This immediately offers a serious deterrent to our younger men because they have been trained to use all the scientific adjuncts of the modern hospital for diagnosis and treatment. Thus, if he is not going to be able to obtain hospital privileges, there is little inducement for him to enter general practice. If he did enter general practice under these circumstances, he would function solely as a clearing station to refer to the various specialized groups those patients that he cannot treat in his office and home. His position would be analagous to the battalion surgeon in the Army who functioned solely to screen the sick from the non-sick, and all interesting problems were referred to the hospital for treatment. This leads to stagnation.

Of course, it is easy to understand how this situation developed. Hospital authorities are concerned with maintaining the quality of medical care provided in their hospitals. Hospital administrators needed standards to measure the training and ability of the physicians desiring staff privileges. The specialty boards met this need adequately by setting up certain minimum requirements for its membership. This resulted in the present day trend of selecting staff physicians solely on the basis of certification. Hospital authorities cannot be blamed

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for using the standards formulated by the medical profession.

National Bodies Act

However, as is so often the case when something becomes a fad, the pendulum has swung too far. The curtailing of hospital privileges by demanding certification, or by simply closing the staff, prevents the competent general practitioner from caring for his patients to the extent of his ability. This is such a manifest injustice that cognizance has been taken of it by all the outstanding groups in American medicine. It is vigorously opposed by the A.M.A., A.B.S., and the Council on Medical Education and hospitals of the A.M.A., as is proven by the following quotations:

"A resolution adopted by the House of Delegates of the American Medical Association in 1946:

'Resolved, that hospitals should be encouraged to establish general practitioner services. Appointments to a general practice section shall be made by the hospital authorities on the merits and training of the physician. Such a general practice section shall not per se prevent approval of a hospital for the training of interns and for residencies.

'The criterion of whether a physician may be a member of a hospital staff shall not be dependent on certification by the various specialty boards or membership in special societies.'

and

"A report of the Council on Medical Education and Hospitals of the American Medical Association:

'It was never intended that staff appointments in hospitals generally, or even in hospitals approved for residencies, should be limited to board-certified physicians as is now the policy in some hospitals. Such policies, if practiced extensively, are detrimental to the health of the people, and therefore to American medicine. Hospital staff appointments should depend on the qualifications of physicians to render proper care to hospitalized patients as judged by the professional staff of the hospital and not on certification or special society memberships. In this opinion, the council has the full concurrence of the Advisory Board for Medical Specialties.'

and

"A resolution adopted concurrently by the American Board of Surgery and the Advisory Board of Medical Specialties:

'The American Board of Surgery is not concerned with measures that might gain special privileges or recognition for its certificants in the practice of surgery. It is neither the intent nor has it been the purpose of the Board of Surgery to define requirements for membership on the staff of hospitals. The prime object of the board is to pass judgment on the education and training of broadly competent and responsible surgeons—not who shall or shall not perform surgical operations. The board specifically disclaims interest in or recognition of differential emoluments that may be based on certification.' "

Effect on General Practitioner

Barring the general practitioner not only decreases the incentive for our younger graduates to enter general practice but it also has another deleterious effect—namely, those men now in practice who do not have hospital privileges become stagnant and retrogressive practitioners and are responsible for the poor quality of medical care rendered in some areas. A medical man must be in association with men who are his peers in order to enhance his knowledge.

Another compelling reason why competent general practitioners must be accorded hospital privileges is the changing concept of medical economics. With the advent of Blue Cross and, here in Rhode Island, of our Physicians' Service, which offers not only surgical and obstetrical benefits but also medical service, more and more people are being treated in the hospitals. Many of these were treated at home before voluntary insurance was sold. Thus, more and more of the general practitioner's patients are being weaned from him.

Paradoxically, the trend toward over-specialization is giving the general practitioner an ever more important role in medicine. As the specialties multiply and become more complex, and their techniques more difficult, there is an increasing need for the highly educated doctor with a wide outlook and wide knowledge, who knows his patient, his environment and family background, and can view his case as a whole.

Technical advances in medicine, the antibiotics and the newer chemo-therapeutics have also increased the value and the services the general practitioner can render, and have made him even more indispensable to the health of the individual.

This trend toward over-specialization is a matter of serious concern and it must be reversed if American medicine is going to remain a free enterprise. The only way to reverse this trend is to make better general practitioners who, through self improvement, can command the respect of the laity and the rest of the profession.

Tonight I am here as a representative of the American Academy of General Practice, namely as President of the Rhode Island chapter. This is a group of outstanding American medical men who have recognized the need of improving the status and the ability of the general practitioner, and once more, through this improvement, regain for him the prestige and rights which he formerly possessed.

continued on next page

This is not a pressure group organized to exert pressure or to obtain privileges for incompetent individuals. Ninety percent of its membership now have hospital privileges.

I ask you only to view our objectives with an open mind. We do not wish to be patronized. We feel that the general practitioner has considerable to offer to the hospital and the specialists. We know that we, in turn, shall be greatly benefited from this association. We do not seek privileges without accepting the responsibility that goes with privileges. We ask that you judge each and every one of us solely on our qualifications.

Dr. McCormick, a member of the Board of Directors of the A.M.A., Chief of Surgery at Maumee Hospital, Toledo, Ohio, Past President of the Ohio State Medical Society, and on whose hospital staff general practitioners have been integrated for fifteen years, said: "When the general practitioner has received the recognition to which he is justly entitled, he grows in knowledge by contact and becomes more proficient, renders better service to his patients and, because of professional association and advice, does not attempt to walk in where angels fear to tread."

Objectives of Academy

I would now like to discuss with you the objectives of the American Academy of General Practice which I think are most commendable:

1. To establish an organization of general practitioners and maintain high standards of general practice.
2. To assist young men in preparing, qualifying and establishing themselves in general practice.
3. To preserve the right of the general practitioner to practice in the hospital to the extent of his ability.
4. To assist in providing postgraduate training for the general practitioner.
5. To promote the art of surgery and medicine for the betterment of public health.
6. To preserve the right of free choice of physician.

What has the American Academy of General Practice done to accomplish these objectives?

1. It has established an organization for general practitioners. There are now approximately 15,000 members, which is a phenomenal growth for a medical organization that is just over two years old. It is the third largest group of organized medical men in the country. We propose to maintain high standards of general practice by requiring that each member must complete 150 hours of postgraduate training every three years. One hundred hours of this may be accomplished by attending staff conferences, clinics, medical seminars or symposiums, and by attendance at state county or local Medical Society meetings. The other fifty hours must be obtained by attending an institution where formal instruction is rendered and which is approved by the Academy. A member cannot renew his membership unless this requirement is fulfilled every three years. This is the only medical organization that I know of which has such a requirement. You certainly will agree with me that such a program is going to stimulate our members. No longer will the general practitioner be looked down on as the man with the proverbial black bag and a few pills, and nothing to offer but his ingenuity and consolation, but in his stead we will offer well trained, well informed and competent up-to-date medical practitioners.
2. There are now in the United States 85 hospitals which have 216 general practice residencies. These residencies vary from two to three years in duration and are designed to give the student a well rounded and well balanced training and background for general practice. Some of our leading schools are offering this program—the Universities of Louisiana, Colorado, Louisville, Kansas and others. This program certainly is going to assist young men to prepare themselves for general practice.
3. Retain the right of the general practitioner in the hospitals.

   There are at present 837 hospitals that have general practice sections. Of course, there are many others that allow general practitioners privileges but these hospitals actually have general practice sections. This section is an integral part of the hospital staff. It is headed by a general practitioner who is elected from the section, and he has a voice in determining staff policy. He sits in at staff meetings with the chiefs of the other sections and has an equal voice. The men in the general practice section conduct their own conferences and discuss their problems. They must attend at least 75% of the staff conferences. They have responsibilities of teaching the intern and residents. The men applying for privileges in this section are judged by the qualifications and credentials committee just as their brother specialists. These men are then given privileges in keeping with their qualifications. There is no overstepping of their privileges because these are clearly defined.

   The University of Louisville now has a department of general practice in its Medical School. This department is headed by a member of the American Academy of General Practice. Finally the student will become

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The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

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POLLUTION

The morning paper shows Governor Pastore turning a valve to divert a daily flow of 4,000,000 gallons of raw sewage from Bucklin Brook into a modern system where it will be properly treated. He was assisted in this pleasant manual labor by Chairman Halloran of the Blackstone Valley Sewer District Authority.

This organization was not in existence and apparently not even contemplated four years ago when the committee on Water Pollution of the Providence Medical Association made its report and this journal followed it with an editorial.

There's a lot of water gone under Red Bridge since then, unfortunately very nasty. But when the Governor turned the valve he stopped some of the filth. Undoubtedly a good start has been made towards decency with more improvement to follow.

We said four years ago that large industries really wanted to cooperate by handling their industrial waste properly. The community was in no position to insist on huge outlays by private interests until human sewage was taken care of. In this connection it was encouraging to read recently a statement by Mr. Shea, Chief, Division of Sanitary Engineering, that one of the largest concerns discharging chemicals into our water is willingly planning to change its ways.

The Rhode Island Medical Journal incurred the displeasure of the Navy not long ago by pointing out that the shore installations at Newport were pouring great amounts of sewage into the harbor. Now we learn that the money is appropriated and this evil is at long last going to be corrected.

A volunteer state committee on pollution has recently made their report in which there is a good deal of detailed optimism about the conditions throughout the state. Such places as the state institutions have remedied what was before decidedly bad.

This is all very encouraging but a series of diagrams recently published in the daily press shows large areas of solid blackness. These areas are not clean and they will not be clean even with what we have done and have planned definitely so far.

The problem is a considerable one and we have got to keep pestering the powers that be or they will most certainly slacken.

The problem of air pollution has also been improved. We have a good official setup for this and a good man at the head of it. We think we can see even now a little improvement. The east side of the city does not have so much grit under foot as formerly. Probably a good deal of this is due to the shift from coal burning locomotives to diesel engines on the railroad.

Certainly our own court house has ceased to be the bad offender that it was. We hear that they are

continued on next page

going to be tough on improper soft coal installations. Once again we voice some optimism about this problem and an admonition that we have to keep working hard.

DOCTORS MUST VOTE

"Politics and medicine don't mix!"

Statements like this frequently are employed by many doctors to justify their failure to register, failure to vote and failure to take part in the political decisions of the local community, the State and the Nation.

Added to this viewpoint is the indisputable and somewhat extenuating fact that the best doctors are extremely busy people, engaged in the night-and-day task of preserving health and saving life.

Nevertheless, this year of decision, 1950, presents American doctors with an undeniable paradox: doctors either must enter the political arena or see politics enter medicine.

For this is not just another election year. It is a year in which medicine itself will be one of the big clay pigeons on the political shooting ranges. The question of Compulsory versus Voluntary Health Insurance--embodying the future not only of the medical profession but of all the American people — will be one of the principal issues in the 1950 Congressional elections.

It is imperative, therefore, that every doctor exercise his franchise this year — his right *as an individual citizen* to register, to vote, and to help influence the political direction of his Nation.

Failure to do so, this year, may mean the ultimate termination of his traditional medical franchise — the right to practice medicine according to ethical professional and scientific standards — not political standards.

ANNUAL REPORTS

Annual reports of committees are not easy to write, as any chairman will attest. They undoubtedly are not always easy reading, for they are concerned in the main with a recount of past work, and a summarization of achievement attempted, gained, or to be sought at a future date.

But they constitute reading that is of vital interest to every Fellow of the Society. The service on committees of the Society, whether elected or appointed, is a service of love. The good of the profession, the advancement of medical science and of public health, and general service to the community in every way possible are tied into the assignment of committee service. To the Fellows who annually accept the task of carrying forward the many activities of the Society, who give unstintingly of their time and energy to meet regularly and to work out the problems of the moment, we all owe a great debt.

The publication of these annual reports is not merely to satisfy the by-laws providing that the Journal shall be the means of publicizing the work of the Society. They appear as information of vital importance to every physician. They stand as a challenge to every Fellow to take it upon himself to become interested in committee work, and to volunteer either to serve on a committee, or to contribute his ideas for the advancement of the work of any and all committees.

DENTAL HONORS

The nation's foremost dentists were singled out for distinction last month in an honor roll published in a special mid-century issue of the Journal of the American Dental Association, commemorating 50 years of dental progress, and the Rhode Island "dentist of the half century" was the late Dr. Charles Albert Brackett of Newport.

Dr. Brackett was nominated for the honor by members of the Rhode Island State Dental Society for his leadership both in the field of dental education and in organized dentistry.

He was one of the founders and a president of the state dental society and served as president of the state board of registration for nine years.

Following his graduation from Harvard Dental School, he served on its faculty and was a member of the school's first administrative board. For the furtherance of dental education, he contributed more than $400,000 to the school.

In tribute to the educator, the late Dr. Charles W. Eliot, president of Harvard, said:

"Dr. Brackett's influence will give to coming generations an invaluable lesson on the immortal worth of character, gentle manners, unselfishness and public spirit."

Dr. Brackett was well-known to the medical profession of this State, and his contribution to the advancement of the professions and the dental health of the public warranted his selection for the historic listing by the national dental association.

CHARITY A "CURSE"?

Oscar Ewing, federal security administrator, received the Sidney Hillman $1,000 annual award for meritorious public service. The prize was presented by Jacob S. Potofsky, who succeeded the late Mr. Hillman as president of the Amalgamated Clothing Workers. It was awarded for Mr. Ewing's work on behalf of "social security," notably compulsory national health insurance. In the course of his remarks, Mr. Potofsky praised the health insurance scheme as a plan that would "destroy the curse of charity" and bring the "best in medical care to everybody."

Charity has been regarded for a long time as a beautiful and noble virtue—"And now abideth faith, hope, charity, these three; and the greatest of

these is charity." But in describing charity as a "curse," Mr. Potofsky meant that those who accept help from others may feel humiliated over their inability to do for themselves.

If it were merely insurance that would end this "curse," it is already available—and from nonprofit institutions. But the Ewing "meritorious public service" requires two other things. One is compulsion from the government to make sure that everyone is insured. The other is large sums from the taxpayers to make up the deficits in the fund collected from the insured.

Assistance given by one or several persons to others in need is "charity" and a "curse." When that assistance is taxed away from all, it is, in the Ewing-Potofsky-New Deal view, no longer "charity" but a "right."

It strikes us that here is the key to the New Deal philosophy. It is the effort to give the less fortunate and the less successful a vested right to be aided by the taxes taken from the successful, the fortunate and the thrifty. The donors are entitled to no appreciation for their contribution: the recipients owe nobody thanks, for charity is a "curse." The extent to which this conception of charity has been accepted may not be generally realized. The Maine farmer who deliberately grows potatoes in unsalable quantities does not feel indebted to his neighbors for getting him out of his hole. He has a "right" to receive from the taxpayers a profit on his unsound venture.

The entire social security program of pensions, unemployment insurance and the like is based on the notion that individuals must be forced to make for themselves and their fellows the provision decreed by an all-wise bureaucracy. The Christian principle of benevolence toward one's neighbors has been converted into a compulsory wealth-sharing, in which any gratitude of the beneficiary is not to the contributor but to the politician who extracted the benefits for him.

Probably this system is now so well accepted that few would change its present applications. But thoughtful people will consider its extension carefully. For once this principle is completely established, all that anyone owns will be held subject to the demands of those who have less, since the "right" of the latter will be cemented, and the exercise of it be limited only by the zeal of their political spokesmen in carrying out the leveling process.

That is why the seeds of Socialism, Communism, or totalitarianism by any other name, are correctly imputed to New Dealism. That is why the worst enemies of democracy, the most violent reactionaries, are those who deny the ability of a free people to manage their own affairs, to dispense their own charity, and who insist that the government become the social guardian who makes and enforces all such decisions.

While the New Dealers in this country have so far sought only to make charity a "curse," other parts of the world have gone farther and made faith a curse also.

Hope, fortunately, is still permissible everywhere.

(Editorial, Chicago Daily News, 3/16/50).

PHYSICAL MEDICINE CONGRESS AT BOSTON

Will hold its twenty-eighth annual scientific and clinical session August 28, 29, 30, 31 and September 1, 1950 inclusive, at the Hotel Statler, Boston, Massachusetts. Scientific and clinical sessions will be given on the days of August 28, 29, 30, 31 and September 1, 1950. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction seminars will be held August 28, 29, 30 and 31. These seminars will be offered in two groups. One set of ten lectures will consist of basic subjects and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapy Technicians or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.



Mrs. William N. Hughes, (left) retiring president of the Woman's Auxiliary, discusses plans for the future with Mrs. Charles L. Farrell, incoming President, at the annual meeting of the Auxiliary.

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Balance Sheet — May 31, 1950

ASSETS

Cash in Banks and On Hand:	April 30, 1950	May 31, 1950	Increase (Decrease)
Operating Account	$58,018.01	$89,635.56	$31,617.55
Accounts Receivable (Subscriptions)	109.97	153.65	43.68
TOTAL ASSETS	$58,127.98	$89,789.21	$31,661.23

LIABILITIES

Accounts Payable (Surg.-Med. Services)	$ 8,456.00	$20,291.00	$11,835.00
Accounts Payable (Hospital Serv. Corp.)	2,022.27	2,669.40	647.13
Accounts Payable (R. I. M. S.)		2,000.00	2,000.00
Accrued Surgical-Medical Expense	20,857.00	32,491.00	11,904.00
Unearned Subscriptions	1,914.65	4,187.30	2,272.65
TOTAL LIABILITIES	$32,979.92	$61,638.70	$28,658.78
Reserves:			
Surgical-Medical Expense	$25,148.06	$28,150.51	$ 3,002.45
TOTAL LIABILITIES AND RESERVES	$58,127.98	$89,789.21	$31,661.23

Statement of Income and Expense

	Month of April, 1950	%	Month of May, 1950	%	Total to Date 5/31/50	%
Income:						
Earned Subscriptions	$30,737.60	100	$39,866.85	100	$112,968.05	100
To Surgical-Medical Reserve	$28,323.53		$35,197.45		$101,764.51	
To General Reserve	2,414.07		4,669.40		11,203.54	
Surgical-Medical Expense:						
Participating Physicians	$15,292.00		$27,731.00		$ 64,520.00	
Non-Participating Physicians	2,269.00		4,464.00		9,094.00	
Total Surgical-Medical Expenses	$17,561.00	57.1	$32,195.00	80.8	$ 73,614.00	65.2
Total Operating Expenses	$ 2,414.07	7.9	$ 2,669.40*	6.7	$ 9,203.54	8.1
Organization Expenses Appli. to 1949			$ 2,000.00	5.0	$ 2,000.00	1.8
Added to Reserves	$10,762.53	35.0	$ 3,002.45	7.5	$ 28,150.51	24.9
Surgical-Medical	$10,762.53		$ 3,002.45		$ 28,150.51	

Monthly Income and Expenses — 1950

	Earned Income	Surgical-Medical Expense	Operating Expense	Net Income Added to Reserves
1 '50	$ 9,074.10 (100%)	$ 4,790.00 (52.8%)	$ 660.71 (7.3%)	$ 3,623.39 (39.9%)
2 '50	13,341.35 (100%)	7,012.00 (52.6%)	924.42 (6.9%)	5,404.93 (40.5%)
3 '50	19,948.15 (100%)	12,056.00 (60.4%)	2,534.94 (12.7%)	5,357.21 (26.9%)
4 '50	30,737.60 (100%)	17,561.00 (57.1%)	2,414.07 (7.9%)	10,762.53 (35.0%)
5 '50	39,866.85 (100%)	32,195.00 (80.8%)	4,669.40 (13.7%)	3,002.45 (7.5%)

*Expenses Charged By Blue Cross Under Operating Agreement — $2,669.40 (6.7%)

continued on page 363

The Neurogenic Approach—

in Peptic Ulcer Therapy

Banthīne*

BROMIDE

Brand of Methantheline Bromide

PHARMACOLOGY

Unlike the antacid drugs, Banthīne does not effect its action within the gastrointestinal canal, but on the nervous mechanism.

Laboratory and clinical observations indicate that it acts as a true anticholinergic drug. Its effects take place at both the parasympathetic and sympathetic ganglions, and at the parasympathetic postganglionic nerve endings.

THERAPEUTIC ACTION

As a result of reducing the vagotonia of ulcer patients, Banthīne consistently decreases hypermotility and usually decreases hyperacidity.

Clinical experience has evidenced the rationale of this approach. Subjectively, ulcer symptoms have been relieved as soon as fifteen minutes after the first dose, with continued relief as long as the drug is continued at regular intervals. Objectively, motor and secretory inhibition has been demonstrated by intragastric balloon, analysis of gastric contents and other laboratory procedures; healing of resistant ulcers has been demonstrated roentgenographically.

TOXICITY AND PRECAUTIONS

Symptoms, such as some dryness of the mouth, mild blurring of vision, slight difficulty of urination or gastric fulness, may occur but usually disappear or decrease on continued medication; if severe, they may require dosage readjustment. Untoward reactions with Banthīne therapy have not been encountered after eighteen months of clinical use.

*Trademark of G. D. Searle & Co., Chicago 80, Illinois.

AVERAGE DOSAGE: *One or two tablets (50 or 100 mg.) every six hours around-the-clock.*

BANTHĪNE IS A PRODUCT OF SEARLE RESEARCH

Galvanic and Sinusoidal Currents in Diagnosis and Therapy



The Burdick Sine-O-Tron provides in one unit *all* important applications of galvanic and sinusoidal currents.

In neuromuscular diagnosis and therapy, in iontophoresis treatment of cervicitis and arthritis, and in electrolysis, the Sine-O-Tron acts smoothly and dependably.

Important among the features of the versatile Sine-O-Tron are its simple operation, choice of current (straight, surging or reversing galvanic; 120 or 420 cycle pulsating direct; or a.c.), range of voltage and current intensity.

THE BURDICK SINE-O-TRON

Galvanic and Sinusoidal Current Generator

For complete literature on The Burdick Sine-O-Tron, see your local Burdick dealer, or write us—The Burdick Corporation, Milton, Wis.

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HOSPITAL BEDS • WHEEL CHAIRS • TRUSSES • BELTS • SUPPORTS • SICK ROOM SUPPLIES

Enrollment by Months

	CONTRACTS				SUBSCRIBERS				
Month	*"P"*	*"C"*	*"D"*	*Total*	*"P"*	*"C"*	*"D"*	*Total*	*Avg. Sub. Per. Contr.*
1 '50	1,418	3,844	6	5,268	3,844	7,996	16	11,856	2.25
2 '50	1,774	849	25	2,648	4,072	1,795	59	5,926	2.24
3 '50	2,351	1,108	38	3,497	6,007	2,283	76	8,366	2.39
4 '50	4,755	1,231	40	6,026	10,802	2,605	81	13,488	2.24
5 '50	2 183	2,910	110	5,203	5,169	6,762	249	12,180	2.34
*6 '50	2,904	2,009		4,913	6,178	4,923		11,101	2.26
Net 6/1/50 (Before Cancellations)				27,634				63,141	2.28

* Preliminary Figure

Report of Surgical and Medical Expenses

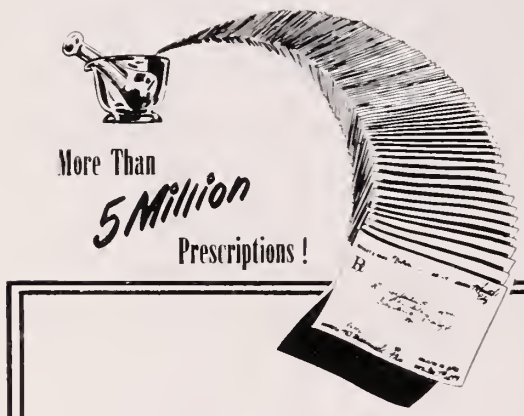
		Month of May 1950			Total to Date May 31, 1950		
		Cases	Amount	C. P. Case	Cases	Amount	C. P. Case
SURGEONS	Hospital	276	$15,705.00	$56.90	533	$30,797.50	$57.78
	Office-Home	54	908.00	16.81	151	2,539.00	16.81
	Total	330	16,613.00	50.34	684	33,336.50	48.74
ASSISTANTS . . .	Hospital	45	640.00	14.22	98	1,417.50	14.46
	Office				2	20.00	10.00
	Total	45	640.00	14.22	100	1,437.50	14.38
ANESTHETISTS . .	Hospital	180	2,252.00	12.51	345	4,560.00	13.22
	Office	15	124.00	8.27	31	256.00	8.26
	Total	195	2,376.00	12.18	376	4,816.00	12.81
TRANSFUSIONS . .	Hospital	3	20.00	6.67	8	45.00	5.63
MEDICAL	Hospital	24	642.00	26.75	58	1,488.00	25.66
TOTAL REPORTED .	Hospital	528	19,259.00	36.48	1,042	38,308.00	36.76
	Office-Home	69	1,032.00	14.96	184	2,815.00	15.30
TOTAL PAID		354	20,291.00	51.10	742	41,123.00	55.42
ACCRUAL FOR UNREPORTED .		193	11,904.00	34.68	584	32,491.00	55.64
TOTAL EXPENSE		547	32,195.00	42.32	1,326	73,614.00	55.52
PARTICIPATING PHYSICIANS . . .			27,731.00			64,520.00	
NON-PARTICIPATING PHYSICIANS .			4,464.00			9,904.00	
MONTH INCURRED:							
January '50			161.00			3,410.00	
February '50			310.00			5,749.00	
March '50			1,530.00			8,694.00	
April '50			7,526.00			12,506.00	
May '50			10,764.00			10,764.00	
TOTAL PAID			$20,291.00			$41,123.00	

PROBLEMS OF GENERAL PRACTICE AND THEIR SOLUTIONS

concluded from page 356

aware of the fact that there is such a doctor as the general practitioner before he becomes an intern.

4. To provide postgraduate training.
   Last year in more than 60 institutions there were courses offered at which the family physician could obtain his 50 hours of formal postgraduate instruction. The ensuing year will find many more institutions offering such courses.
5. Our fifth aim was to improve and promote the art of medicine and surgery for the betterment of public health. This objective will be accomplished because of accomplishment of the previous four which will give us more competent and better trained general practitioners.
6. We will preserve the right of free choice of a physician because more men will be induced to enter the field of general practice and, therefore, the rural areas will obtain the medical care for which they have been clamoring and for which they have been in such dire need. This is the one complaint that the socializers have against the medical profession for which we cannot offer satisfactory rebuttal. This program will correct that fault.



YES, it took more than 100 years. We're proud that these years have been devoted to an endeavor to preserve life. It is gratifying to know that our small contribution has added to the health, happiness and well-being of the community. We are making every effort to maintain our leadership with our next 5 million prescriptions.

Blanding's

155 WESTMINSTER ST. and WAYLAND SQUARE
Tel. GA. 1-1476 and PL. 1-1341

Membership in the Academy is open to men who are:

1. Graduates of Class A medical schools and who have served an approved internship.
2. Members of their local, county or state medical societies.
3. Of good moral character, and who have shown an interest in post graduate work.

Progressive Program Contemplated

We do not want agitators, or those who have axes to grind, or malcontents. We are looking for the competent and capable general practitioner, and we hope that by improving him we will be able to raise the level of others.

You certainly will agree with me that this is a forward, progressive, constructive program which is rapidly accomplishing its purpose. However, the real improvement will be to the patients who will find available to them high class medical service conveyed by men and women in whom they have great confidence as a result of intimate contact. The great problem of medical cost will be partially resolved by the more general and less specialized advice. The first haven our grandfathers sought when illness struck was the family physician, and our younger generation must be taught that it should still be the family physician.

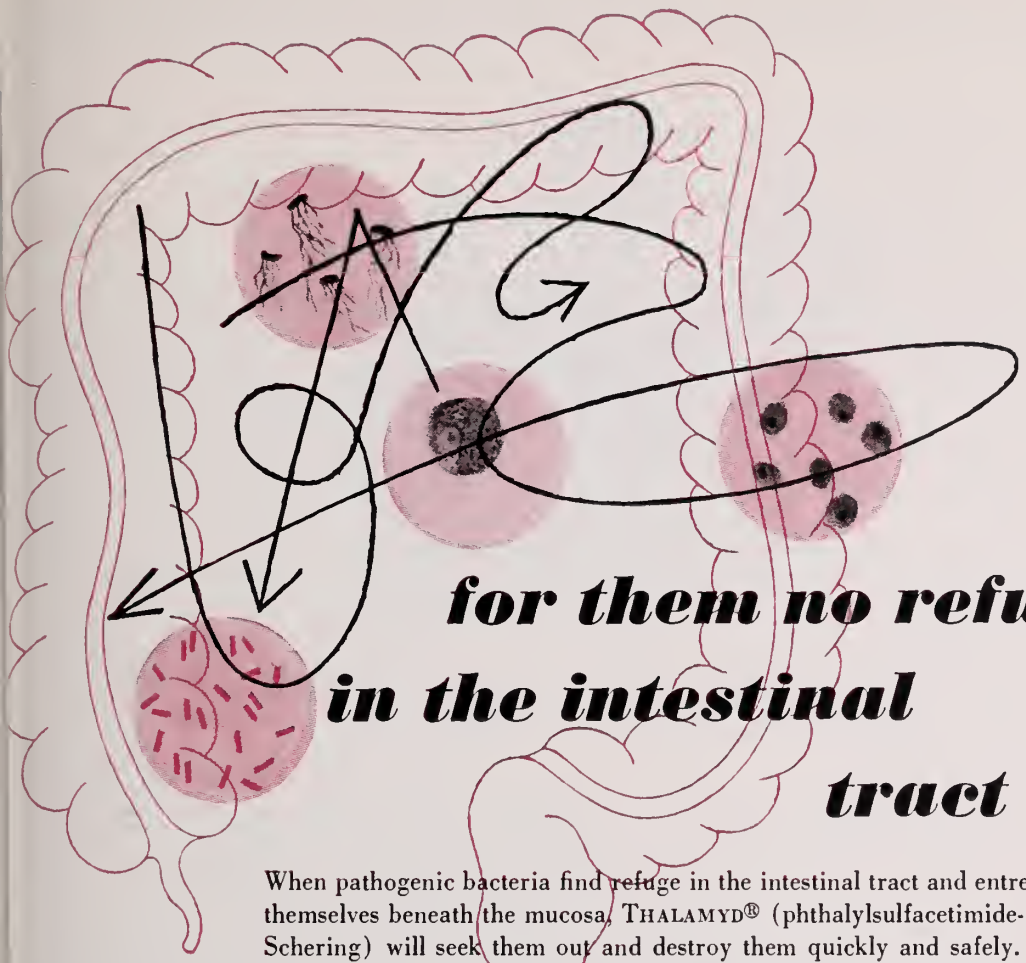
There is no one in the medical profession who has a greater claim on hospital recognition than the G. P. He or she does not wish to teach surgery, gynecology or radiology, or any other specialty. Nor do they desire promotion above their merits and qualifications, and such recognition should not be accorded. There is, however, a great chasm between over-recognition and exclusion. Neither is justifiable. The betterment of the profession, the expansion of hospital and medical service to the public, and the good of the public health from a scientific and financial viewpoint demand that those of you in the fields of standardization, hospital administration and specialty practice "render to Caesar the things that are Caesar's." Never in the history of American medicine has such a course been more necessary than the present time, as it is conceivable that the fundamentals of American democracy may hang in the balance.[2]

BIBLIOGRAPHY

[1] The Relationship of the Gen. Practitioner to the Hosp. Staff. Paul A. Davis, M.D., Iowa State Med. Journal, Dec. 1949. Vol. XIII, No. 12, Page 1137.

[2] The Gen. Practitioner and the Hospital Staff, Edward J. McCormick, M.D., Ohio State Med. Journal, Vol. 46, Jan. 1950.

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for them no refuge in the intestinal tract

When pathogenic bacteria find refuge in the intestinal tract and entrench themselves beneath the mucosa, THALAMYD® (phthalylsulfacetimide-Schering) will seek them out and destroy them quickly and safely. THALAMYD is highly effective against most gastrointestinal pathogens whether they are within the lumen of the gut or have penetrated the muscularis. A nonabsorbable sulfonamide, THALAMYD is unique in being able to diffuse into the bowel wall, but not into the blood stream.

THALAMYD

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More efficient than other nonabsorbable compounds, yet safer than absorbable drugs, THALAMYD is indicated in enteritis, dysentery due to Shigella and other susceptible organisms, ulcerative colitis and preoperative sterilization of the gastrointestinal tract.

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ANNUAL REPORTS—1949-50

THE RHODE ISLAND MEDICAL SOCIETY

GENERAL MEETING . . . MAY 11, 1950

In accordance with the By-Laws of the Society a general meeting open to all registered members and guests was held at noon on Thursday, May 11, 1950, the second day of the 139th Annual Meeting. The meeting was called to order by Dr. Peter Pineo Chase, the President.

The Secretary reported the slate of officers and elected committees elected by the House of Delegates at its May meeting.

Dr. Charles J. Ashworth, president-elect, was escorted to the platform, and he addressed the membership briefly. The other officers elected by the House of Delegates were called individually to be recognized by the meeting.

The Secretary reported that at its meeting on May 3 the House of Delegates had adopted the report of the Committee on the revision of the by-laws, and he read the report of the committee, citing the proposed by-law changes.

It was moved, seconded and unanimously voted that the proposed changes in the by-laws be adopted.

The meeting was adjourned by the President.

Respectfully submitted,
MORGAN CUTTS, M.D., *Secretary*

BOARD OF TRUSTEES

During the past year the Board of Trustees has authorized the Providence Medical Association to establish its Medical Bureau, a 24-hour secretarial telephone exchange for the medical profession, in the basement room.

The addition of this facility has demonstrated anew the potential value of the building to the Profession. The Providence Medical Association has guaranteed the cost of improvements in the basement, including the partitioning of the room, the installation of lights, and new flooring.

A new electric drinking cooler has been installed on the first floor of the library.

Recently the Trustees were faced with a sizable expenditure for a new boiler to replace the one that has been used since the building was erected in 1912. We are faced annually now with the deterioration of some of our equipment, and we must anticipate annual expenditures for property repairs.

The Council has authorized the Trustees to study and report to it regarding the heating system of the building, with the thought in mind that the coal burning equipment might be changed to oil burning. The new boiler recently purchased will lend itself to such a changeover.

Within the next few months an addition to the heating system will have to be installed to provide adequate heat for the Medical Bureau in the basement.

Respectfully submitted,
BOARD OF TRUSTEES
EDGAR S. POTTER, M.D., *Chairman*

REPORT OF THE TREASURER

The cost of operation of the Society during 1949 was approximately $3,600 more than the previous year, due in major part to the increasing activity of the Society's many committees, plus the rising costs in general for all utilities, equipment, and building maintenance.

Although our cash balance at the end of 1949 was approximately $2,700 less than that available at the end of the previous year, this difference is offset by the fact that we have accounts receivable from loans to the Rhode Island Medical Society Physicians Service in the amount of $2,000, and from the Providence Medical Association in the amount of $795.67. Thus our assets were slightly higher as of January 1, 1950, than they were the first of the previous year.

Our invested reserve of general funds is $5,000 which is invested in U. S. Treasury securities.

The activities of the Society in recent years have greatly increased. We now have two general meetings a year, our annual meeting has been expanded, the cancer, diabetes, and public relations committees, for example, have carried forward extensive programs for the membership, and the national meetings in which we must have representation are numerous. All these important activities make increasing demands upon the finances of the Society.

The Medical Library is an old building, and each year we are faced with a new problem of repair. Recently a new boiler had to be installed at great expense, and the entire heating system has to be re-studied.

The various special funds of the Society have remained unchanged during the year, except that

continued on page 368



SPOIL THE APPETITE . . .

CONTROL OF APPETITE is frequently beyond the power of human will, a fact that explains most cases of obesity. Fortunately, appetite can be checked by administration of certain sympathomimetic drugs, such as *Propadrine*® phenylpropanolamine HCl, a development of Sharp & Dohme research notably free of the unpleasant side effects associated with ephedrine. ALTEPOSE tablets, a new formula for control of obesity, provide PROPADRINE HCl, 50 mg. (¾ gr.), to reduce the desire to eat; *thyroid*, 40 mg. (⅔ gr.), to increase metabolism; and DELVINAL® vinbarbital, 25 mg. (⅜ gr.), for mild sedation. ALTEPOSE tablets spare the obese patient the pangs of hunger, making low-calorie diets more acceptable, speed metabolism of excess fat and carbohydrate, and tend to suppress nervous tension and anxiety. The proper dose must be determined for each individual. ALTEPOSE tablets are supplied in bottles of 100 and 1,000. Sharp & Dohme, Philadelphia 1, Pa.

spare the patient

SHARP & DOHME

Altepose® TABLETS

for treatment of obesity

ANNUAL REPORTS

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the income from the various investments continues to be low.

The Medical Journal continues to meet its operative costs from its own advertising and circulation revenue, and therefore has not required any financial assistance from the Society.

* * *

REPORT OF THE TREASURER

Fiscal Year — 1949

Cash balance, General Fund, January 1, 1949	$11,921.03
Receipts, 1949 (Exhibit A)	33,903.57
Total	$45,824.60
Expenses, 1949 (Exhibit B)	$36,638.56
Balance	$ 9,186.04

* * *

Cash on hand, General Funds, January 1, 1950	$ 9,186.04
Cash in general funds credited to Special Funds (Exhibit C)	*—1,769.18*
Cash on hand for Operating Expenses, January 1, 1950	$ 7,416.86

* * *

Cash on Hand in General Funds, January 1, 1950	$ 9,186.04
Accounts Receivable:	
Rhode Island Medical Society Physicans Service	2,147.78
Providence Medical Association, Medical Bureau	795.67
Invested Funds, U. S. Treasury Certificates	5,000.00
Total assets, January 1, 1950	$17,129.49

EXHIBIT A — RECEIPTS — 1949

Annual meeting, dinner payments	$ 1,470.00
Council Meetings, dinner receipts	168.00
Dividends from invested funds	750.58
Donations	65.00
Dues from members	26,800.00
Exhibits, balance due for 1949 meeting	1,449.50
Midwinter meeting, dinner receipts (February 4)	462.50
Midwinter meeting, dinner receipts (December 14)	427.00
Miscellaneous (Reimbursements from AMA, New England Medical Council, Conference of Presidents, Medical Bureau, etc.)	758.10
Providence Medical Association	1,552.89
Total	$33,903.57

* * *

EXHIBIT B — EXPENSES — 1949

Annual Meeting, including dinner payments	$ 3,523.48
Books	223.55
Committees:	
Arrangements for Annual Meeting	24.24
Cancer	267.45
Diabetes	171.00
Health Insurance	57.00
Medical Grievance	3.75
Public Relations	217.59
Council meetings, dinner payments	302.83
Delegates to AMA and national meetings	871.33
District Societies' Officers Conference	92.67
Donations and dues to Organizations	120.00
Electricity	79.69
Fuel	758.75
Gas	53.42
General Expenses (Society)	1,240.50
Insurance	1,295.28
Legal	609.74
Library	1,122.75
Loans (Medical Bureau, Providence Medical Association)	345.83
Midwinter meetings, including dinner payments	1,209.21
Office supplies and equipment	975.77
Postage	486.17
Printing	772.90
Repairs, Library building	338.15
R. I. Medical Society Physicians Service (loan)	2,154.78
Salaries	17,264.45
Taxes	1,708.30
Telephone	347.98
Total	$36,638.56

EXHIBIT C — SPECIAL FUNDS — 1949

J. W. C. ELY FUND

A memorial fund established in 1912 by the son and the granddaughter of Dr. J. W. C. Ely, in the amount of $1,500, to be called the J. W. C. Ely Fund and the income from which was to be used for periodicals.

Investments

52 shares, New England Electric Company

Cash in General Fund of Society

Balance January 1, 1949	$ 770.65
Stock dividends, 1949	41.60
Total	$ 812.25
Periodicals purchased, 1949	132.50
Cash balance in General Fund, January 1, 1950	$ 679.75

* * *

continued on page 370

Double, double *less* toil and trouble



The double salt, Calpurate— product of Maltbie Laboratories research— means less trouble from drug therapy in certain cardiovascular conditions.

Calpurate is absorbed slowly and steadily, which means—
. . . more sustained blood levels
. . . longer-lasting relief

Calpurate is marked by low solubility and does not liberate free theobromine alkaloid in the stomach, thus making possible—
. . . prolonged, uninterrupted administration in cardiac decompensation, coronary disease (angina pectoris, thrombosis), and hypertension

Dosage: 1 or 2 tablets three times daily; Powder: 7 to 15 gr. three times daily.

Available in bottles of 100, 500, 1000 and as Powder in 1-ounce bottles.

Calpurate THEOBROMINE CALCIUM GLUCONATE, MALTBIE
Tablets and Powder

Calpurate *with Phenobarbital*
Tablets

For Trouble-Free Prolonged Cardiac Therapy

MALTBIE LABORATORIES, INC. *Newark 1, New Jersey*

ANNUAL REPORTS

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ENDOWMENT FUND

Started in 1912 when the Trustees (of the Fiske Fund) announced that they had voted to take the remuneration allowed them by the will, i.e., 2 1/12 of the annual income, amounting that year to $69.69, and to present this sum to the Rhode Island Medical Library to be the foundation of a "maintenance fund" for the support of the Library Building.

Investments

U. S. Treasury Bonds	$2,000.00	
Dividend, 1949		$ 50.00
74 Shares, Providence Gas Company	906.50	
Dividend, 1949		37.74
Total		$ 87.74
Used for Library Building Maintenance		$ 87.74

* * *

E. M. HARRIS FUND

Established in 1921 by a donation of $5.000 by Dr. E. M. Harris for "upkeep of the Library Building."

Investments

25 shares, Consolidated Edison Electric Company

64 shares, Nicholson File Company

Dividends, 1949 (Used for upkeep of Library Building)

Consolidated Edison Electric Company	$ 125.00
Nicholson File Company	192.46
Total	$ 317.46

* * *

HERBERT TERRY FUND

Established in 1928 by a donation of $2,000 from C. B. and C. H. Kenyon in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of same for the Library.

Investment

96 shares, Providence Gas Company

Cash in General Funds of Society

January 1, 1949	$ 4.30
Dividends, 1949	48.96
	$ 53.26
Books and periodicals purchase, 1949	61.00
Loss (Paid from general funds)	$ 7.74

* * *

JAMES R. MORGAN FUND

Established by a donation of $500 in 1929 to be used for current expenses.

Investment

43 shares, Providence Gas Company

Dividends, 1949 (Used for current expenses)	$ 21.93

* * *

JAMES H. DAVENPORT FUND

Established in 1930 by a donation of $1,000 for the purchase of books for the Davenport Collection of non-medical books written by physicians.

Investment

89 shares, Providence Gas Company

Cash in General Fund

January 1, 1949	$ 1,016.77
Dividends, 1949	45.39
Total	$ 1,062.16
Books purchased, 1949	— 14.30
Cash balance in General Fund, January 1, 1950	$ 1,047.86

* * *

THE CHARLES F. GORMLY FUND

Established by the Society in 1945 with a cash balance of $102.51 accruing from surplus contributions from members of the Society for the purchase of an oil painting of Dr. Gormly presented to the Society in 1943. The Fund was established for the purchase of medico-legal books to form the Charles F. Gormly collection.

Cash balance in General Fund, January 1, 1949	$ 58.32
Books purchased, 1949	16.75
Cash balance in General Fund, January 1, 1950	$ 41.57

* * *

continued on page 372

Strand Optical Co.

PRESCRIPTION OPTICIANS

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PROVIDENCE, R. I.

GASPEE 4696

appetite must be controlled



"The greatest problem in preventive medicine in the United States today is obesity."[1] And today it is well-known that "*The only way to counteract obesity . . . is by a restriction of food intake.*"[2]

'Dexedrine' Sulfate controls appetite, making it easy for the patient to avoid overeating and thus to lose weight safely without the use (and risk) of such potentially dangerous drugs as thyroid. In weight reduction 'Dexedrine' "*is the drug of choice because of its effectiveness and the low incidence of undesirable side effects.*"[1]
Smith, Kline & French Laboratories • Philadelphia

Dexedrine* Sulfate tablets • elixir

A most effective drug for control of appetite in weight reduction

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

1. Walker, W.J.: Obesity as a Problem in Preventive Medicine, U.S. Armed Forces M.J. 1:393, 1950.
2. John, H.J.: Dietary Invalidism, Ann. Int. Med. 32:595, 1950.

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FRANK L. DAY FUND

Established in 1927 by a donation from the estate of Dr. F. L. Day, to be utilized for the purchase of books.

Investment

3,000 shares, Canadian National Railway Company

Cash, Industrial Trust Company, checking account

Balance, January 1, 1949		$ 678.45
Dividends, 1949, Canadian National Railway		135.00
		$ 813.45
Books purchased and Bank charges, 1949	$ 133.43	
Balance, January 1, 1950		$ 680.02

Assets:

Cash balance, January 1, 1949	$ 1,195.26
Receipts, advertising and subscriptions	14,072.56
	$15,267.82

Expenses:

Copyrights	$ 48.00	
Editorial Staff	118.29	
Postage	247.30	
Printing Journals	11,160.06	
Printing, (Misc.)	337.03	
Refund	2.00	
Supplies and Equipment	17.65	
Editor's Expenses	1,040.00	
		$12,970.33
Total	$12,970.33	
		$ 2,297.49
Cash balance 2/7/50	$ 2,297.49	
Accounts Receivable		
Blanding & Blanding	25.00	
Brewer Company	21.25	
Desitin Chemical Co.	42.50	
Assets, February 7, 1950	$ 2,386.24	

G. RAYMOND FOX, M.D., *Treasurer*

Scientific Work and Annual Meeting

The Committee on Scientific Work and Annual Meeting carried out the request of the House of Delegates that the midwinter meeting be held in December, and a session was held at Newport, Rhode Island, on December 18, 1949. Guest speakers at this meeting were Dr. Wingate Johnson, of North Carolina, Dr. Meyer Saklad of Providence, and Dr. Creighton Barker of New Haven, Connecticut. The meeting was well attended.

The Committee has completed plans for the 139th Annual Meeting of the Society to be held at Providence on May 10 and 11, and it anticipates that this session will prove of great scientific value to every Fellow of the Society.

The midwinter meeting for this year has been set for Wednesday, December 13, 1950, and it will be held in Woonsocket, Rhode Island.

Respectfully submitted,

CHARLES J. ASHWORTH, M.D., *Chairman*

REVISION OF THE BY-LAWS

At the request of the Council of the Society a committee on the revision of the by-laws was appointed, and it submits herewith a summary of the revisions it would recommend to the House of Delegates for approval, and for submission to the General Session of the Society to be held on May 11, 1950.

The Committee has endeavored to clarify the by-laws in accordance with the present operation of the Society, and in accordance with previous amendments that have been adopted from time to time. The summary below indicates the revisions that would be made. The text of the official regulations with these amendments indicated, will be available for inspection by the House of Delegates on May 3.

Respectfully submitted,

ROLAND HAMMOND, M.D., *Chairman*
JOHN E. DONLEY, M.D.
G. RAYMOND FOX, M.D.

Summary of By-Law Changes Proposed

ARTICLE III. *Membership*

Section 7 is amended to provide that dues shall be payable within the calendar year before suspension is effective. The present rules sets October 1. The pro rating of dues is also eliminated in view of the fact that members elected in the latter part of the year have their dues applied for the ensuing year.

* * *

ARTICLE IV. *Component Societies*

Section 6 is amended to provide for the election of alternate Councillors.

* * *

ARTICLE V. *Officers*

Section 1 is amended by deleting provision for the office of assistant secretary. All future reference to assistant secretary in the by-laws is also eliminated.

Section 9 is amended to provide that the Secretary shall be ex officio a member of all Standing Committees.

Section 9 change word "member" to "Fellow" in lines 14, 17, and 23. Change word "membership" to "Fellowship" in line 18.

Section 11 is amended to provide that the annual budget shall be presented at the September meeting of the House of Delegates.

* * *

ARTICLE VI. *House of Delegates*

Section 3 is amended by deleting the provisions that the Council shall set the order of business for the House of Delegates.

Section 4 is amended to provide that the month of April, instead of the month of May, shall be set for one of the meetings of the House of Delegates.

Section 7 is amended to provide that the AMA delegates shall be elected in September and take office the following January 1 for two year terms.

Section 7 also amended to provide that the Council shall name a Nominating Committee of 5 of its own members to prepare a list of candidates for offices and standing committees, and the Council will then review the list and submit a final list to the House of Delegates.

* * *

ARTICLE VIII. *Sessions and Meetings*

Section 2, line 3, change word "members" to "Fellows."

Section 7 is amended to provide that papers read at meetings shall not exceed 30 minutes instead of 20 as now provided.

This section also amended to remove present unworkable provisions relative to the Society's claim on scientific papers presented at annual and special meetings.

* * *

ARTICLE IX. *Finance*

Change word "members" to "Fellows" section 1, line 3.

* * *

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Certified MILK

The *Highest* Quality Milk

MEDICALLY APPROVED FOR

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Most Nutritious

Certified Milk is Your Cheapest Food

ARTICLE X. *Standing Committees and Boards of Trustees*

Sections 1 to 15 amended to provide as follows: Correct committee titles based on previous amendments. Addition of Medical Grievance and Defense as standing committee, and definition of its work.

All committees to be composed of 9 members elected by the House of Delegates, in addition to the President and the Secretary, ex officio.

Section 8 where word "members" is used substitute "Fellows."

* * *

All sections or parts of sections and articles as presently written that are inconsistent with these proposed amendments would be amended accordingly to carry out the full and true intent of the revisions proposed above.

CANCER

The activities of the Committee this year have consisted principally in the preparation and the putting on of the second annual Cancer Conference. This Conference included as speakers men of reputation in the field of cancer who spoke on early diagnosis and treatment. The meeting was well attended, and the papers were excellent.

In addition to the activities concerned in this conference, the Chairman, who is an ex officio member of the Board of Directors of the Rhode Island Cancer Society, has attended numerous meetings both of the Board of Directors and of the Executive Committee.

At present, plans are well underway in arranging for a third annual Cancer Conference which will be held on October 18, 1950, at the Medical Library. It looks as if we were going to have a very well rounded group of speakers. Many acceptances have already been received.

Respectfully submitted,

GEORGE W. WATERMAN, M.D., *Chairman*

RELAX IN JAMESTOWN!

Own A Comfortable Summer Home Or Shore-Front Lot. For A Good Selection Contact.

MEREDITH & CLARKE, INC.

REALTORS — INSURORS

Jamestown, R. I.

FOR APPOINTMENT PHONE 100

CASH SICKNESS ADVISORY COMMITTEE

During the year your Committee worked with the officers of the Division of Employment Security in the development of a plan under which impartial medical examinations are performed by individual physicians instead of by the staff physicians of the agency. This change was the result of much planning, and a complete report was issued to every physician in the state.

We report that the new program has been most satisfactory. The number of impartial examinations has been drastically reduced, and yet the cost of medical administration has not increased, nor has the benefit total been increased because of the new system.

Every Fellow of the Society was given the opportunity to become an impartial examiner, and the list of those accepting this work was mimeographed by the executive office and supplied to the Division of Employment Security.

We note with interest also that the Agency has provided for the attendance of a physician at all Cash Sickness appeal hearings held by the board of review, a recommendation made by the Society a year ago.

A matter now under consideration is that of establishing some schedule of lengths of periods of disabilities to expedite the processing of claims.

Respectfully submitted,

HERMAN C. PITTS, M.D., *Chairman*

UNIFORM FEE SCHEDULE for GOVERNMENTAL AGENCIES

At the request of the Council a committee consisting of the chairmen of various committees of the Society that are concerned with fee schedules (i.e. Veterans, Vocational Rehabilitation, Cash Sickness, Health Insurance, Tuberculosis, Social Welfare, etc.,) has studied various proposals for a Uniform Fee Schedule for wards and dependents of government.

The Committee recommends to the House of Delegates the adoption of the Michigan schedule, as revised December 1, 1949, with the following fee changes and additions:

Page 2 — Examinations by Specialists

0026	Complete Examination of heart, including electrocardiogram with interpretation	$15.00
	with fluoroscopy	20.00
0026	A Complete general routine examination plus electrocardiogram and interpretation 4 leads	$20.00
	12 leads	25.00
(new)	Complete history and general routine examination	$15.00

0028	Physical examination of heart and lungs including pertinent history	$10.00
0030A	With preliminary K.U.B. film	$40.00
0039	Psychiatric examination (first hour or less)	$15.00

Surgical Assistants

When the nature of an operation is such that the services of an assisting licensed physician are necessary:

When surgical indemnity is:	Assistant's indemnity is:
$50 to $99	$10.00
100 to 150	15.00
over 150	20.00

Respectfully submitted,
HERMAN C. PITTS, M.D., *Chairman*

HEALTH INSURANCE

The Health Insurance Committee has continued to supervise the program of the Rhode Island Plan, meeting with insurance company representatives from time to time to consider problems relating to the program.

With the inauguration of Physicians Service, the committee carefully reviewed the status of the Rhode Island Plan, and upon advice of legal counsel, and others, decided that the program should be continued under approval of the committee as an added incentive for the public to acquire health insurance on a voluntary basis. Our action is duplicated in the state of Wisconsin where both the Society's non-profit program and its plan utilizing insurance carriers is working effectively.

The companies participating in the Rhode Island Plan have been asked to liberalize their contracts insofar as possible, and the master schedule of indemnities has been amended to include medical visits in the hospital, as is permitted under the same schedule used by Physicians Service.

The committee finds that the Society cannot require the insurance companies to write a single standard policy, identical to that offered by Physicians Service, as such action would be tantamount to restriction of trade, forcing all competitors to write a single standard policy. Instead, the companies have been encouraged to make as liberal allowance as possible in their policies under the Plan to aid the people of Rhode Island.

The Committee feels that it should clarify one misunderstanding that may exist regarding insurance company activities in the health and accident field. The Rhode Island Plan operates under a reduced schedule of indemnities, established by the House of Delegates in order to reduce the premium cost of the insurance insofar as possible. This schedule lists fees below the prevailing charges that

continued on next page

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Both 86.8 Proof

Every drop of Johnnie Walker is made in Scotland—using only Scotland's crystal-clear spring water. Every drop of Johnnie Walker is distilled with the skill and care that comes from many generations of fine whisky-making.

Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky . . . the same high quality the world over.



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BLENDED SCOTCH WHISKY

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physicians in their area may rightfully make. The maximum fee in the schedule is $150, regardless of the operative procedure performed.

However, many industrial concerns, and labor organizations negotiating for employee benefits, seek liberal allowances. As a result the insurance industry has been in a position to offer contracts on a group basis offering a high schedule of indemnities than that offered by the Rhode Island Plan. As a result they have presented such coverage in the best interest of the persons to be insured.

The purpose of this Society in establishing prepaid voluntary insurance was to extend such coverage as widely as possible. We have scaled the schedule of fees to be paid physicians below prevailing charges in order to get the insurance in the hands of persons in lower income groups. However, where persons are above these income groups, or where labor-management negotiations result in the purchase of more substantial coverage, other insurance should be available.

Answers from eight of the thirteen companies in the Rhode Island Plan have so far been received in a recent survey which indicate more than 52,000 persons having surgical insurance. This index of coverage, when augmented by the insurance sold by all other insurance companies would indicate at least 75,000 persons in this state as having surgical-medical insurance.

Your committee feels that the Rhode Island Plan should be continued in the best interests of the public.

Respectfully submitted,

ROCCO ABBATE, M.D., *Chairman*

INDUSTRIAL HEALTH

The bill relating to the medical society's thoughts on changes in the compensation bill was presented to Governor Pastore last year but he found it apparently advisable to pigeonhole the same, and no action was forthcoming.

Duffy My Druggist

Plainfield St. at Laurel Hill Ave.,

Providence, R. I.

Reliable Prescription Service
Since 1922

There have been but few meetings of this committee during the year, however, the committee sponsored a lecture and demonstration by Dr. George G. Deaver of New York on Rehabilitation at the Medical Library on the evening of April 12th. From reports received this would appear to have been worthwhile and successful.

The Chairman of the Committee is also Chairman of a Subcommittee on Physiological Safety, and this report will be forthcoming at the time of the Governor's Conference on Industrial Safety, May 16, 1950.

By authority of the Council of the Society, the Chairman of the Committee attended the annual Industrial Health Congress in New York sponsored by the American Medical Association. The excellent scientific programs, and contacts made at this meeting have been most helpful to the chairman, and through him to the committee.

Respectfully submitted,

STANLEY SPRAGUE, M.D., *Chairman*

LIBRARY

The activities of a Library are measured by the statistics of the work done, and therefore we present the following figures covering the service of our Library to the Fellows and the Community. The last reference is made advisedly, because appeal is constantly being made to the Library for information of all kinds regarding medical matters, and these inquiries come from both medical and lay sources, so that the Library has become in some real sense a Medical Reference Bureau. No account has been kept of the number of requests for advice sought by telephone, but it is safe to say that 20 to 30 calls per day are answered; in many cases this requires consultation of reference books, and other sources.

During the year, there were 2390 visitors to the Library, 379 more than last year. Of these 1365 were physicians, the balance including many students from the various institutions of learning in the city and the surrounding territory. Here again is evidence of the influence of the Library in the community.

Circulation:

Charged out and returned	270	books
	1,435	Journals
At present charged out	58	books
	215	Journals
Total number of items	1,978	
Inter library loan		
loaned to other libraries	49	books
	520	Journals
	569	items

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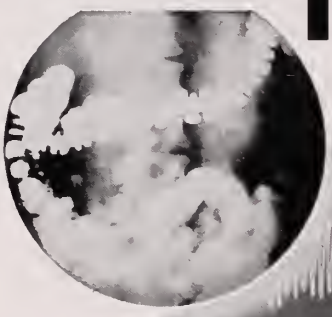
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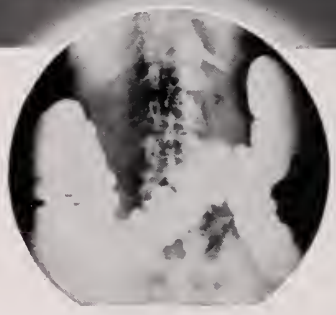
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Borrowed from other Libraries ..... 3 books
12 Journals

Reference Work:

186 bibliographies prepared, in addition to the large amount of information given by telephone, as already noted.

Periodicals:

We are currently receiving 243 Journals

During the year two new subscription journals were added to the list.

"CIRCULATION"—R. I. Medical Society

"ARCHIVES OF INDUSTRIAL HYGIENE & OCCUPATIONAL MEDICINE"—Providence Medical Association

Binding:

139 volumes of Journals were bound.

Accessions:

Purchase: (21 Day Fund; 4 Davenport Fund; 2 Gormly Fund) Total 27

From the Rhode Island Medical Journal, sent by the publishers for review. 40

191 books were given to the Library by members, institutions, and friends. The list of donors is long and is evidence of the continued interest of the profession. Two gifts were outstanding; 171 books and periodicals were received from the Library of Dr. N. Darrell Harvey; 283 volumes of Journals from the State Hospital for Mental Disease. In each case, these gifts helped to complete files of certain journals.

78 bound volumes of Journals were added

With the additions of the past year, there are now in the Library about 38,475 books, plus a great number of pamphlets and reprints. Of these 24,430 have been catalogued. Until all these are catalogued it will be impossible to do more than estimate the actual total. As in the Report of last year, we would emphasize the importance of cataloguing; it did not seem feasible to undertake it during the past year, but our Library is a valuable one, and all the books should be available for reference. At present, there are about 14,000 volumes still uncatalogued.

It has been suggested that there be placed in the Reading Room a case in which there could be displayed from time to time rare books, old instruments, and objects of historical interest. This is in line with the practice in many Libraries, and has proven to be of much interest.

During the summer, the Librarian, Mrs. Helen DeJong, was granted a leave of absence for a period of three months, for travel abroad. In the interim, the affairs of the Library were carried on by Miss Dickerman, assisted by Miss Betty Farrell.

Respectfully submitted,
HERBERT G. PARTRIDGE, M.D., *Chairman*

continued on next page

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MEDICAL ECONOMICS

In 1948 the Society adopted a resolution requesting that life insurance companies revise upward their fee schedule for physical examinations and reports. This was the second action taken on this matter by a state medical association, New Jersey having preceded us.

To the Committee on Medical Economics fell the task of carrying the negotiations with the insurance companies, and the committee of last year under the chairmanship of Dr. William P. Davis carried on extensive studies and conferences.

Since that time the problem has won nationwide support from medical societies, and the insurance companies have admitted the need for increasing their fees which had remained unchanged for a period of fifty years. The increase has not met the fee proposed by the Rhode Island Medical Society of $10, for most of the companies have settled upon a $7.50 fee for the full medical examination, or for a disability examination.

The new scale adopted by one major life insurance company, which is probably typical of those now adopted by a great many companies, is as follows:

Full medical examination	$ 7.50
Disability examination	7.50
Full medical examination, together with special heart examination	10.00
Special heart examination subsequent to full medical examination	5.00
Junior Medical examination	5.00
Short form examination	4.00
Additional blood pressure and pulse reading	3.00
Additional blood pressure reading	2.00
Additional pulse reading	2.00
Additional home office specimen	1.00

"The fee for an attending physician's statement submitted on our regular form, has also been increased to $3.00."

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The latest report from the Bureau of Medical Economic Research of the American Medical Association lists the following insurance companies as having increased their fee schedules:

Aetna Life Insurance
Bankers Life (of Iowa)
Connecticut General
Connecticut Mutual
Continental Assurance
Equitable (of Iowa)
Equitable Life Assurance of N. Y.
Fidelity Mutual
Guardian Life of New York
Home Life
Jefferson Standard
Life Insurance of Virginia
Manhattan Life
Mutual Life
Mutual Trust of Chicago
National Life and Accident
National Life (Vermont)
New York Life
Pacific Mutual
Pan American
Phoenix Mutual
Pilot Life
Security Mutual of Binghamton, N. Y.
Southland Life (Dallas)
Southwestern (Dallas)
Sun Life of Canada
Travelers

Two years ago, in initiating action on the question of fees for examinations for insurance companies, the House of Delegates of our Society adopted the following recommendation:

> That the fee for the initial examination be a minimum of $10, and that fees for subsequent examinations be consistent with the present office fee, but with a minimum of $3; that an E.K.G. and interpretation be $15; and that special examination, such as blood and sugar tolerance tests, be $10.

Your committee now refers this entire question to the House of Delegates for its decision in view of the action that has been taken by the major insurance companies in the intervening time.

Respectfully submitted,

SAMUEL D. CLARKE, M.D., *Chairman*

MEDICAL DEFENSE AND GRIEVANCE

A change in the activities of this committee has been noticed during the past year. Although malpractice suits continue to be brought into the courts, they have often been preceded by a letter to the Society outlining a grievance and with a request for redress or reparation. These communications

continued on page 382

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ANNUAL REPORTS

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are investigated and the opinion of the Committee sent in writing to the correspondent.

In many cases nothing more is heard of the matter.

At the present time at least four suits for malpractice are awaiting action in the courts. At the December, 1949, meeting the House of Delegates of the American Medical Association adopted a resolution urging all constituent associations to develop programs whereby patients can present grievances to a proper committee.

We have received requests from at least two state societies asking for information as to the conduct of these hearings.

It would seem advisable that these hearings be held before the entire committee with all sides represented. With such a procedure it may be expected that grievances can often be reconciled and further legal procedures avoided. The committee again wishes to emphasize the importance of reporting promptly any case where a patient seems likely, by his attitude, to resort to legal measures for adjustment of a dispute or dissatisfaction with treatment administered, even if the case has not been referred to a lawyer.

Respectfully submitted,
ROLAND HAMMOND, M.D., *Chairman*

PHYSICIANS SERVICE

Subsequent to the January meeting of the House of Delegates at which the medical members of the board of directors of the Rhode Island Medical Society Physicians Service were elected, a meeting was held and six lay representatives were selected. These laymen who are serving as members of the board of directors this year are:

Mr. Thomas C. Dignan, President of the Narragansett Electric Company
Mr. Emil E. Fachon, Vice President of the Bulova Watch Company, Inc.
Mr. Walter F. Farrell, President of the Union Trust Company
Mr. Felix A. Mirando, Secretary-Treasurer of the Imperial Knife Company
Mr. George R. Ramsbottom, President of the Seekonk Lace Company of Pawtucket
Mr. John Shepard II, of The Shepard Company

The entire board of directors has met and has formulated policies and programs for the effective operation of Physicians Service. The board has established an executive committee, a finance committee, a professional advisory committee, and a joint operations committee.

Close cooperation has been given the Blue Cross officials in their task of merchandising the Physicians Service contracts. The Joint Operations Committee has given freely of its time and energies, meeting often, to clarify the many problems that are bound to arise in the furtherance of the program. We are appreciative of the enthusiastic efforts of Mr. Stanley Saunders, executive director of Physicians Service, and his staff, for their excellent promotion work in the first five months of the plan's operation.

By the end of this month Physicians Service anticipates a total enrollment of close to 50,000 subscribers, approximately one seventh of the eligible population, thus making our Plan the fastest growing one in the nation.

We are pleased to report that the Fellows of the Society have responded excellently to our appeal that they serve as participating physicians. At this time we have 638 physicians so enrolled.

The coming months promise to bring us new challenges as we cope with the problems incidental to the expansion of Physicians Service. We ask that every Fellow of the Society cooperate fully with our program, and that they communicate promptly to the executive office of the Society for information on any phase of it upon which clarification is required.

Respectfully submitted,
JOSEPH C. O'CONNELL, M.D., *President*

PUBLICATION

The Rhode Island Medical Journal, official publication of the Society, continues to bring credit upon the medical profession of this State by the excellence of the articles that have appeared in it during the past year. Many requests have been received for reprints of various scientific papers we have published.

Through its editorial comment the Journal has endeavored to present the views of the Society and many of the editorials stimulated favorable comment in the daily press. The editorial staff has done a commendable job during the year, and credit is due especially to Doctor Peter Chase who has dis-

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charged the dual offices of Editor-in-Chief of the Journal and President of the Society.

The advertising revenue is not as ample as it was during and immediately after the war period. However, the Journal receives excellent consideration from advertising agencies, and the business management is competently handled through the executive office. The members of the Society undoubtedly have but a limited knowledge of the tremendous amout of work that goes into the complete production of our monthly publication, including the bookkeeping and billing of some fifty advertising accounts each month. The committee on publication desires to express its sincere appreciation of the efficient and loyal work of our Editor-in-Chief and of our Executive Secretary to whose efforts much of the success of the Journal is due.

The Journal completed the fiscal year with a cash balance sufficient to meet its current operation, and thus it continues to operate efficiently without any appropriation from the Society.

The Committee urges the Fellows of the Society to prepare and to submit scientific papers for publication in the Journal during the coming months.

Respectfully submitted,

JOHN E. DONLEY, M.D., *Chairman*

PUBLIC LAWS

All legislation proposed to the General Assembly is checked by the executive officer of the Society to determine how such measures would affect public health or medical care in the State. Particular proposals are then submitted to the Committee on Public Laws, which, with advice of legal counsel, has prepared opinions of the various measures, and has made known the views of the Society on them to the proper committees of the General Assembly and to the Governor.

In the session recently concluded several proposals were strongly opposed by the committee. Of particular note was a proposed act that would weaken the basic science law and thereby the licensure standards of the State for those who would practice the healing art. This measure was not referred out of the Assembly committee.

A protest was made against a measure that would have allowed a statement of fact or opinion on the subject of science or art contained in a published treatise, periodical, book or pamphlet, in the discretion of the court, to be admissible in actions of contract or tort for malpractice. A lengthy statement of objections was submitted to the Assembly committee regarding this proposed act, and the measure was subsequently not reported out to the legislature.

Objection was also voiced to a proposal for a comprehensive state wide compulsory health insurance system on the grounds that the Physicians Service, Blue Cross, and the insurance industry were providing adequate insurance on a voluntary basis, and there is no need for a compulsory tax system to be considered in Rhode Island.

Among the measures enacted by the Assembly, and subsequently signed by the Governor, of public health interest, were the following:

An act providing for the administration of first aid and/or other medical services in places of employment. Under this act firms employing less than 400 must employ one or more persons qualified as first aid workers, and those employing more than 400 must set aside and equip a special accident room. Standing orders for nurses are to established in accordance with those published by the American Medical Association in 1943.

* * *

An act amending the general laws relating to jury duty, and providing that on written claim therefore physicians and surgeons (among others) would be exempt from serving as jurors. The Society made known its stand on this legislation early in the session. (See R. I. Medical Journal, February issue, 1950, page 80)

* * *

An act amending the Medical Examiners statute enacted in 1949. The amendments raise the salary of the chief medical examiner to $9,000 annually, plus travel expense, allow for vacation and sick leave, drop the requirement that he would have to be a pathologist, provide for the engaging of an assistant medical examiner, and specify duties of county examiners.

A sub committee of the Council of the Society made recommendations to the Governor and to the Attorney General regarding amendments to the 1949 statute, but the solution offered by this committee was not accepted.

The Committee on Public Laws took no action on this amended act in view of the fact that the Society had already made known its views, both this year

continued on next page

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through the special Council committee, and a year ago through the joint committee of the Society and the Bar Association.

* * *

An act appropriating for the fiscal year ending June 30, 1950, the sum of $329,300 to Rhode Island Hospital, $70,800 to Newport Hospital, and $6,400 to Woonsocket Hospital for "partial reimbursement for service to public ward patients for acute medical or surgical conditions, or maternity care." These appropriations were made in accordance with the statute enacted in 1948 in which it was resolved that voluntary general hospitals are eligible to appeal for state assistance for the purpose as noted above.

* * *

Amendments to the state workmen's compensation act passed by the Assembly included one providing that "neither the employee nor his dependents shall be entitled to compensation for disability for death resulting from such occupational disease, unless such occupational disease is due to the nature of his employment and was contracted therein. The time limit for bringing suit under this section shall be 24 months from the date of disablement, and the date of contraction of the disease shall not be a limiting factor."



Another amendment permits the per diem payment for hospital stay to be raised to $10 as a maximum.

* * *

An act providing for the establishment of a committee on children and youth and preparation for participation by Rhode Island in the 1950 White House Conference.

* * *

A resolution granting an extension of time to the special commission to investigate the advisability of establishing facilities in this state for the study treatment and care of inebriates.

* * *

A resolution upon the death of Dr. John F Kenney, former President of the Rhode Island Medical Society.

Respectfully submitted,

ALBERT H. JACKVONY, M.D., *Chairman*

PUBLIC POLICY AND RELATIONS

The Committee met frequently throughout the year and all sessions were well attended. Many problems were presented and all aspects thoroughly explored. A detailed description of our activities would require a voluminous and time consuming report that I will therefore merely list the activities of the committee, and I am prepared to discuss in detail any phase on which a delegate desires more specific information.

The committee began the year with a dinner at the Hope Club for the district society presidents and secretaries. We had 100 per cent representation. At this meeting the district society officers were urged to develop their own public relations programs with special emphasis on the problems of night and emergency call service—elimination of any local points of friction—the establishment of contacts with civic groups and editors of local papers. Each person present was presented with literature and a booklet entitled "Public Relations for County Medical Societies."

Following this meeting a representative of the committee visited in turn each of the district medical societies of the State and brought the message of public relations to the entire membership.

Your committee took cognizance of the press reports relating to the release of bookies and petty criminals from jail on the recommendation of physicians. Every case was investigated—the findings reported to the Council—and recommendations made to prevent repetition of the incident.

We also investigated all "letters to the editor" and news reports critical of the medical profession. In each case the facts were evaluated and the situation analyzed and remedies proposed.

Further committee activities were as follows:

1. We analyzed Senate bill 1456 and released a summary of this act to the members of the Society.
2. Interviewed editors and corrected misrepresentations and distortions appearing in Editorial columns. In every case better press relations resulted.
3. We made detailed analysis of critical editorials and corrected the material for the benefit of the editor.
4. Replied to Attorney General McGrath's charges of AMA dictatorship in the press.
5. Evoked favorable editorial comment in two weekly newspapers regarding the Whitaker Baxter campaign against socialized medicine.
6. Supplied weekly newspapers with cartoon material on socialized medicine. This material was used in three instances by the weekly papers.
7. Arranged for the appearance of Dr. Marjorie Shearon in Providence as a speaker for the meeting of the Woman's Auxiliary.
8. Arranged for two general meetings of the memberships of the Rhode Island Medical Society and the Woman's Auxiliary as indoctrination courses to acquaint the membership of both organizations with the subject of Socialized Medicine. At one of these meetings Dr. Dunlop, formerly a British physician, spoke on Socialized Medicine in England.
9. At the request of the AMA your chairman presented a paper at the Annual Public Relations Conference held at AMA headquarters in Chicago. A summary of this paper appeared in the December issue of the Rhode Island Medical Journal.
10. Your chairman was also invited by the AMA to go to Chicago and Washington and participate in the opposition to HR 6000.
11. Members of the Committee have appeared as speakers before six service clubs, four employee organizations, three colleges, two schools of nursing as well as a radio broadcast and a dental society public information program.
12. All members of the committee have been completely informed of all AMA activities and the actions of Congress through news releases from the Washington office of the AMA and from the Secretary's office in Chicago.
13. Public relations material from other states and AMA headquarters have been reviewed by the committee and used to shape the course of our own activities.

continued on next page

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14. The Woman's Auxiliary have as a representative on our Committee, Mrs. George Bowles, who has been most cooperative.

15. Mrs. William N. Hughes, President of the Woman's Auxiliary, has been of much help in participating in the planning of our Speakers Bureau. We are also grateful to Mrs. Edward V. Famiglietti, Mrs. Arthur Hardy, Mrs. Joseph C. Johnston, Mrs. Arnold Porter, Mrs. Fred Webster, as well as Dr. Freeman Agnelli, Dr. Donald DeNyse, Dr. Osmond Grimes, Dr. Charles Millard, Dr. Orland Smith, for attending the series of lectures of socialized medicine.

    The committee provided text books—pamphlets, lecture notes and reference material on the medical, economic, and social aspects of health in the United States in an effort to develop a nucleus for a speakers bureau. During the course we utilized lantern slides, charts and our tape recorder. We believe, that as a result, we have an excellent speakers bureau fully informed and technically trained to espouse the cause of medicine under any circumstances.

    We are particularly proud of this accomplishment.

16. Your chairman has written and your committee has published a treatise on "Health Insurance—Voluntary vs. Compulsory" for use by physicians as well as students in schools and colleges who may be desirous of information on the subject in a simple and readily understandable form.

17. A package library in a folder describing the medical library has been prepared for distribution to libraries, schools, colleges and other interested parties.

18. Upon the advent of John T. Flynn's book "The Road Ahead" your committee made copies available to the Library, and sent illustrated advertising postcards to all members of the Medical Society calling attention to this book and urging its purchase and distribution.

19. Through the news clip service we have been completely informed of all press releases regarding medical care and doctors. We are happy to report less criticism and much more favorable press at this time.

20. By authority of the Council we published RIMSCOPE, one issue of which has already been sent you. Other issues will follow at irregular intervals. The purpose of this public relations bulletin is to call your immediate attention to special conditions and important events affecting your welfare. We hope it will command instant attention, and study when you receive it as it will stress VITAL news not ordinarily found in the Medical Journal.

21. The problem of adding a public relations director to the executive staff has been given a great deal of time and attention by the committee. A local organization prepared and described a program for us, several interviews were held with the director and the committee found that the cost of an all out public relations program was prohibitive. The employment of an additional member of the staff would be feasible only as an assistant to the executive secretary, Mr. John E. Farrell. If the proper person can be obtained at a price within what we are willing to pay we recommend that such an addition to the executive staff be made. We also recommend that Mr. John Farrell direct all staff activities and delegate to the assistant such problems and duties as he may from time to time desire to undertake.

    We further recommend that the House authorize a press relations conference whereby the committee would invite editors and managers of daily and weekly newspapers in the state to participate in a panel discussion or open forum for an entire day. This session to be held at the Medical Library with a buffet lunch at noon and dinner at one of the clubs in the city that night. The purpose of this would be to exchange views and to arrive at a more mutual understanding.

    We recommend that the House take cognizance of the need for night and emergency service and that it go on record as affirming the principle that the health and welfare of the people is the direct responsibility of the whole medical profession. We suggest that the House direct to the district medical soci-

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eties to concentrate every effort in providing the solution to this problem in each locality in the state.

We propose for the next year a campaign to acquaint the Rhode Island public with the facilities available for medical care in this state and to inform them as to how to use such facilities to the greatest advantage.

Respectfully submitted,

CHARLES L. FARRELL, M.D., *Chairman*

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BOOK REVIEW

PSYCHIATRIC SECTIONS IN GENERAL HOSPITALS by Paul Haun, M.D., Med. Sc.D., Assistant Professor of Psychiatry, Georgetown University Medical School. Architectural Record division of the F. W. Dodge Corp., N. Y., 1950. $4.00.

The desirability and many advantages of a complete psychiatric unit in a general hospital are clearly set forth in the first section of this book. It would be difficult for any practicing physician or thoughtful layman to disagree with the reasons given for the necessity of the proposed facilities.

In working out this type of unit, the use of an architect to assist the planning board is stressed as it is felt this department should not be haphazardly added but should be carefully integrated with the hospital as a whole. There are many plans given in detail to choose from with a preference as to location given to the top floor of the hospital building.

There are certain practical problems involved which could be discussed more freely with added interest to the reader, for example, the length of stay (short for study and diagnosis, long for treatment and rehabilitation) and the assurance that other hospital patients would not be disturbed or endangered by psychiatric patients in the same building. The use of a separate building attached to the main hospital by a tunnel was not discussed.

On the whole, I feel this book contributes a great deal in bringing out the need for better psychiatric care in most communities and the great advantage of having a psychiatric unit in a general hospital accessible to all.

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(See page 403)

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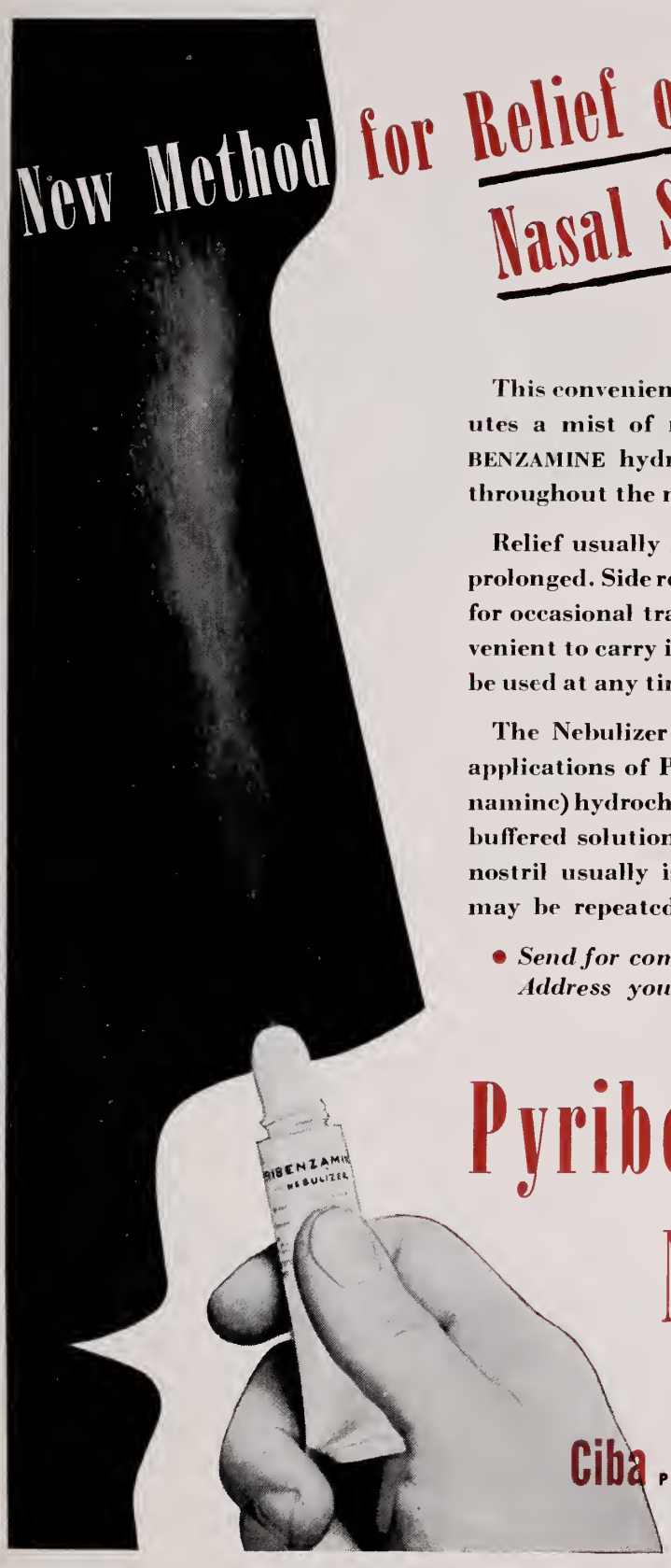
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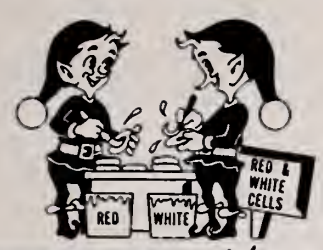
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MONDAY, SEPTEMBER 18 —

"THE PREVENTIVE ASPECTS OF HEART DISEASE"

DAVID B. RUTSTEIN, M.D., of Boston, Massachusetts
Professor of Preventive Medicine, Harvard Medical School

MONDAY, SEPTEMBER 25 —

"AN EVALUATION OF METHODS OF TREATMENT OF HYPERTENSION"

WILLIAM S. MCCANN, M.D.
Professor of Internal Medicine, School of Medicine and Dentistry, Rochester University; Physician-in-Chief, Strong Memorial Hospital, Rochester, New York.

MONDAY, OCTOBER 2 — (Joint meeting with Providence Medical Association.)

"TYPES OF CONGENITAL HEART DISEASE AMENABLE TO SURGERY"

ROBERT E. GROSS, M.D.
William E. Ladd Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Children's Medical Center, Boston.

MONDAY OCTOBER 9 —

"EARLY MANIFESTATIONS OF CONGESTIVE HEART FAILURE AND THEIR MANAGEMENT"

C. SIDNEY BURWELL, M.D.
Research Professor of Clinical Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital, Boston.

MONDAY, OCTOBER 16 —

"PATHOGENESIS OF ANGINA PECTORIS AND SOME CLINICAL IMPLICATIONS"

HERRMAN L. BLUMGART, M.D.
Professor of Medicine, Harvard Medical School; Physician-in-Chief, Beth-Israel Hospital, Boston

MONDAY, OCTOBER 30 — (Tentative)

"RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE"

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Photograph: Peter Pineo Chase, M.D. and James L. Gamble, M.D. 418

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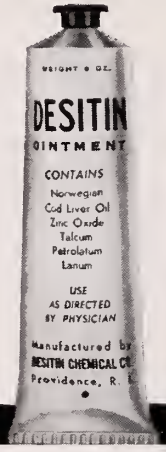
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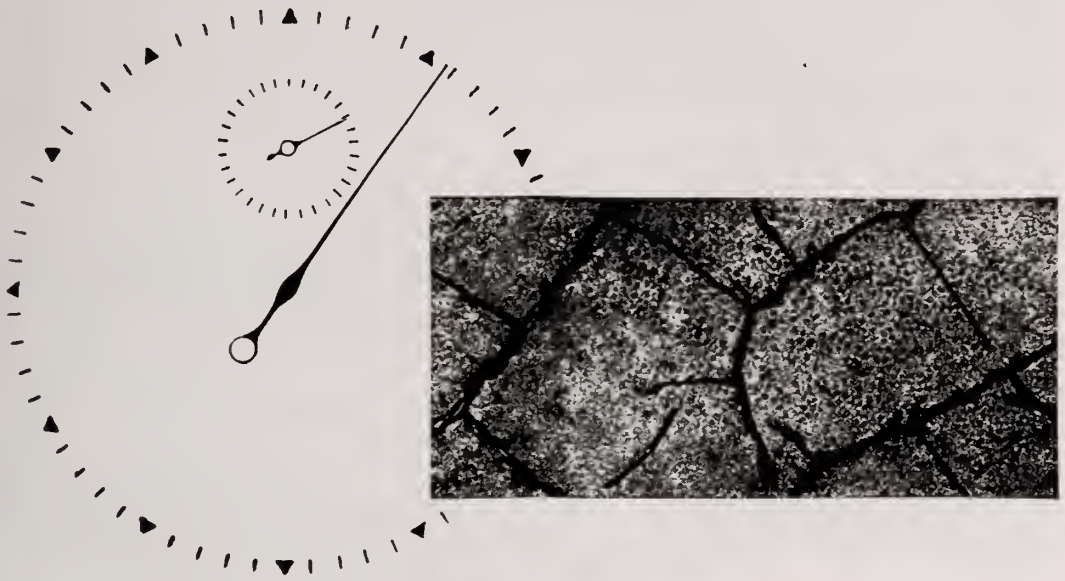
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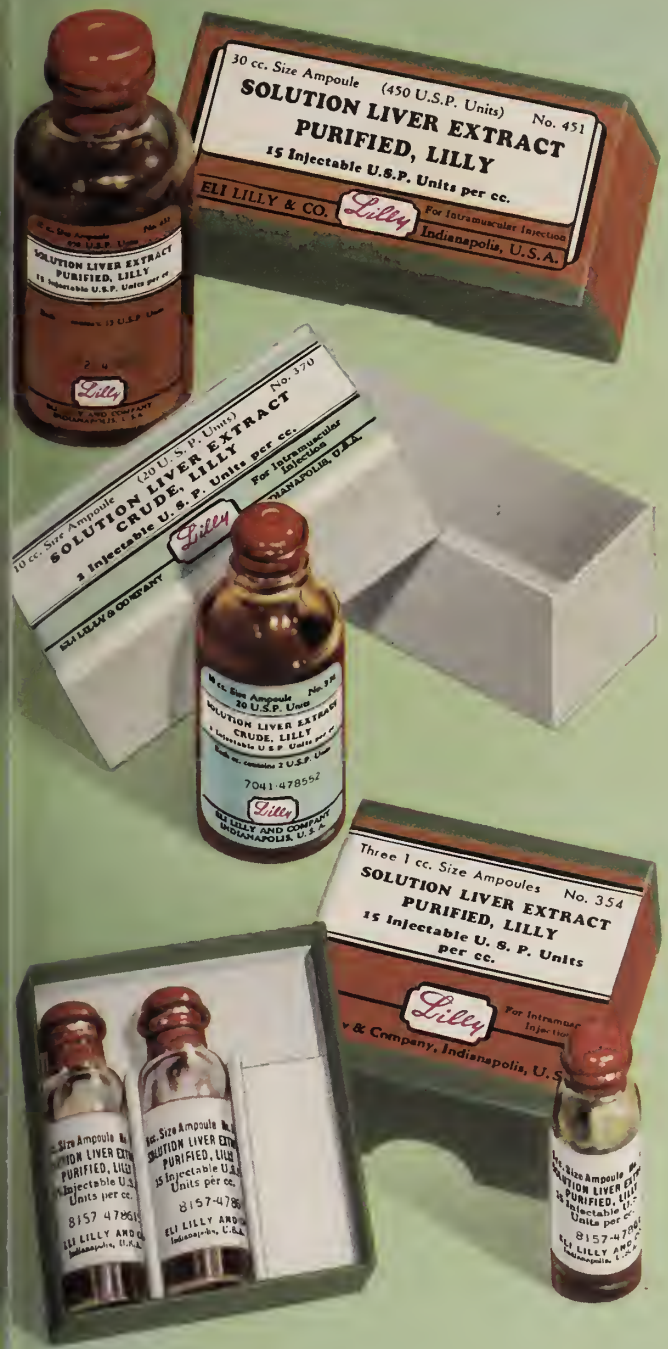
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THE NINTH ANNUAL CHARLES V. CHAPIN ORATION*

BODY FLUIDS AND THE RATIONALE OF FLUID THERAPY

JAMES L. GAMBLE, M.D.

The Author. *James L. Gamble, M.D., of Boston, Massachusetts. Professor of Pediatrics, Harvard Medical School and Graduate School; Recipient, Borden Award for 1946; President, American Pediatric Society, 1944; Editor-in-Chief, JOURNAL OF CLINICAL INVESTIGATION from 1941-1947; 6th Harvey Lecturer at New York Academy of Medicine, 1947; President, New England Pediatric Society, 1934.*

I so greatly appreciate the honor of being asked to give the Chapin Oration that I did not confess that I have no oratorical prowess. So now I am embarrassed by being obliged to use lowly language in discussing the body fluids which deserve to be dealt with eloquently.

For the purposes of this talk, the body fluids will be considered as two anatomical and physiological entities; extracellular and intracellular fluid. As shown by this crude diagram (Figure 1), extracellular fluid is composed of the blood plasma and the interstitial fluid which lies between the vascular compartment and the tissue cells of the body. As regards dimensions, extracellular fluid may be taken as about 20% of body weight and intracellular fluid as 50%.

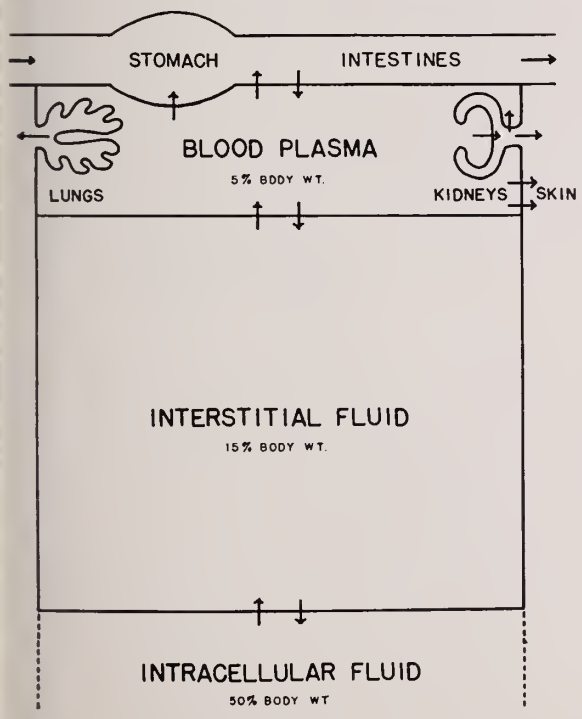


FIG. 1

Having used the word entity, we must at once qualify it by acknowledging an intimate functional relationship between these two fluids, a main feature of which we will now consider. In order that chemical events within the tissue cells may proceed correctly it is necessary that physical conditions such as temperature, reaction and osmotic pressure be held closely stationary. This requirement is understandable if we recall that the rates at which various processes of chemical change proceed are differently altered by change in physical circumstances. So it is evident that the almost innumerable chemical transactions which together accomplish what we call metabolism would rapidly fall out of adjustment if physical conditions were not approximately constant.

The stability of physical properties in cell fluid rests on the degree of their constancy in extracellular fluid. We owe to Claude Bernard recognition of this requirement by the tissue cells for environmental constancy and the concept of extracellular fluid as our immediate or, as he called it, our internal environment. Biological history clearly sustains this concept. According to geological record the early forms of life developed in the pre-Cambrian ocean. There, so we are told, occurred for the first time an aggregation of substances which exhibited a continuous and automatically stabilized chemical activity. We can easily postulate as the required basis for this rather delicate chemical experiment a constancy of physical properties in the surrounding medium. This sea water excellently provided. Sea water is a so-called buffered solution because it contains the weakly acid substance carbonic acid and its alkaline salt bicarbonate. This

* Presented before the Rhode Island Medical Society at its 139th Annual Meeting, at Providence, May 10, 1950.

continued on next page

pair of substances provides the required stability of reaction. The total concentration of substances is immovable because the ocean is so big and so its osmotic value is fixed. Temperature is also nearly constant. Then of course sea water is mostly water and according to Lawrence Henderson water has an incomparable biological fitness. By this word "fitness" we are to understand, I suppose, a suitability of the many components of the Great Experiment which was eventually so successful as to produce a Lawrence Henderson.

To continue our Just So story. Before our extremely remote ancestors could come ashore to enjoy their Eocene Eden or their Paleozoic Palm Beach, it was necessary for them to establish an enclosed aqueous medium which would carry on the role of sea water. This is what extracellular fluid is and does. It replaces sea water in performing two important services to the organism; the transport of nutrient and waste materials which is a simple task and the preservation of environmental physico-chemical constancy, which is a very intricate assignment.

The establishment of an enclosed aqueous medium in which physical properties are held closely stationary in the presence of a widely fluctuant demand for transport of many and various chemical substances was a large undertaking. Besides an intrinsic suitability of the medium itself it required the invention of quite a lot of apparatus. An obviously necessary piece of equipment was a pump to stir and propel the medium. The necessary transactions with our external gaseous environment also had to be arranged for. Besides the heart and the lungs, another very remarkable organ of regulation had to be devised before the internal medium could be established. The kidney is often referred to as an organ of excretion. This is a very inadequate and disrespectful designation. Were the removal of waste substances its only service a much simpler organ would suffice. The structural and functional complexity of the kidney is required for the preservation of an approximately constant chemical pattern in extracellular fluid. McCallum, regarding the establishment of the enclosed aqueous environment as the largest forward step in the history of the animal organism, has described the kidney as the organ par excellence of evolution. Since damage to the heart, lungs or kidneys, or to various other organ systems may dangerously disturb our internal environment we may say that the ultimate objective of a large part of medical science is defense of the functional integrity of extracellular fluid against obstacles imposed by disease.

In order to understand the functional performance of a part of the body we must begin by learning its structure. The framework of the body fluids is composed of chemical units called ions which derive from substances known as electrolytes for the reason that when they enter into solution their molecules fall apart and produce two species of ions one of which carries a positive and the other a negative electrical charge. The ions with a positive charge are called cations and those with a negative charge anions. The cations are the basic radicals and the anions are the acid radicals of the molecules from which they derive. The concentrations of these ions in the body fluids are individually governed and are held at closely stationary values.

The greater part of the framework of the body fluids derives from the inorganic salts of the food intake. These inorganic ions being nonoxidizable have a suitable durability for their structural rôle. But this framework also contains two important organic components protein and carbonic acid.

The electrolyte composition of extracellular fluid is described by the two middle diagrams on this chart (Figure 2). The normal values for the

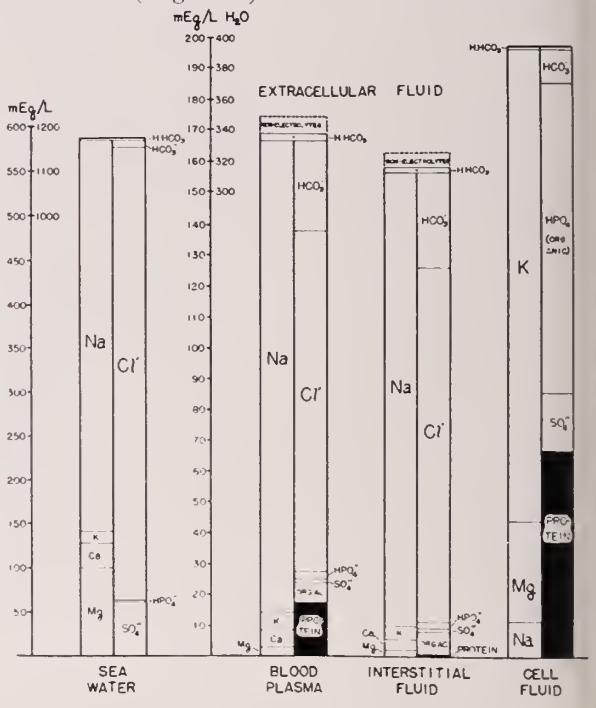


FIG. 2

individual cations or potential base in terms of their chemical equivalence are super-imposed in the left hand and those for the anions or acid radicals in the right hand column, and, as you see, the columns are of equal height.

The purpose of these two diagrams is to display the almost identical ionic patterns of blood plasma and interstitial fluid. We find only the small differences in concentration of the individual components which is referable in terms of osmotic law to the much larger quantity of the non-diffusible component protein in the plasma. So that although extracellular fluid lies in two compartments it is quite clearly a continuous medium.

A value for the sum of the concentrations of the non-electrolytes, such substances as urea and glucose which do not dissociate into their component ions, is placed across the top of the diagram. As you see, they occupy a relatively small amount of space although a larger quantity of these substances than of the electrolytes is transported daily by extracellular fluid. All that the non-electrolytes ask for is expeditious conveyance. The electrolytes on the other hand while they are being transported compose, as we have said, a chemical structure which determines the physical properties of extracellular fluid. This is the meaning of the large prominence of the electrolytes.

The history of extracellular fluid is clearly indicated by the resemblance of its ionic pattern to that of sea water shown by the first diagram. We find the same set of inorganic components in roughly the same relative amounts. The chemical skeleton of sea water is thus plainly visible in extracellular fluid. The total electrolyte concentration of present day sea water is, as shown by the ordinates, several times that of extracellular fluid. But this is an easy hurdle for the biological historian since we know that the salinity of the sea has been steadily increased over the eons by salts carried into it by the rivers of the land and so it is a simple surmise that the concentration of electrolytes which we find in extracellular fluid measures the value for sea water at the time that our internal environment was established.

So we find that the animal organism carries on in the same aqueous medium in which it began. It is rather surprising that being an inveterate experimentalist, it has refrained from tinkering with its original environment once it got it enclosed. Instead, it has spent an immense ingenuity on accurately preserving its Cambrian cradle. The biological sanctity of this solution of several simple salts is very impressive. Apparently not only did it permit the inception of the experiment which we call life but remains its inviolable basis.

That the animal organism can do what it likes with the electrolytes behind the boundaries of protoplasm is shown by the last diagram which describes the electrolyte structure of intracellular fluid. Here the large cation component is potassium instead of sodium and on the anion side we find phosphate instead of chloride and a large aconcentration of protein. So we have these two fluids separated by a gossamer curtain, the cell boundary, which have altogether different ionic patterns in defiance of the known laws of diffusion of electrolytes across a membrane. To the physical chemists this is a major biological marvel. At any rate we can say that, however it has been achieved, it is the basis of the privacy of protoplasm.

Having said that the stability of biochemical processes rests on the physico-chemical constancy of our internal environment, we will now attempt to indicate very briefly the relation of the chemical structure of extracellular fluid to the important physical properties which we call reaction and osmotic pressure. This we can observe in the accessible portion of extracellular fluid; the blood plasma.

The first diagram on this chart (Figure 3) describes the normal electrolyte structure of the

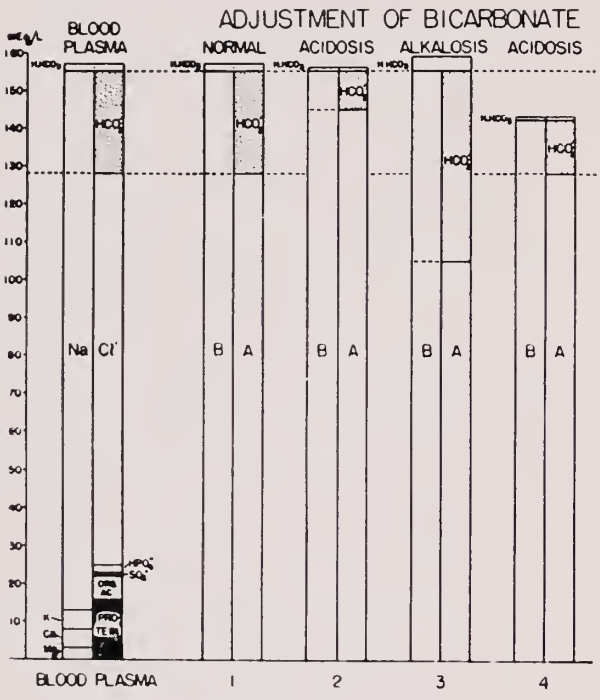


FIG. 3

plasma. It may be well to note here that each of its components has a particular physiological assignment which requires a closely stationary concentration. Collectively they compose a chemical structure which determines the reaction and the osmotic pressure of the plasma.

We will first consider the relation of this structure to reaction. The reaction of the plasma rests, as regards its immediate control, on the relative concentrations of the weakly acid substance carbonic acid and its alkaline salt bicarbonate. That is, it is the ratio and not the absolute quantities of these substances which determines the concentration of ionized hydrogen which is our measure of reaction. The small concentration of carbonic acid at the top of the diagram is sustained by the respiratory mechanism. Below it is the plasma bicarbonate which is composed of the concentration of bicarbonate ion, — HCO_3, together with the base which it covers. The normal value for bicarbonate ion, indicated by the speckled bloc, requires integrity of the entire electrolyte structure for which the

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kidney is mainly responsible. That is, a change in any other part or parts of this Ionic or possibly Doric structure will cause a change in bicarbonate. As shown by the other diagrams on the chart, bicarbonate ion is the adjustable component which preserves total cation-anion equality. For instance, if the sum of the other anions (A) is increased we find equivalent reduction of bicarbonate. The displaced bicarbonate ion is released as carbonic acid and falls under the government of the respiratory mechanism. In the next diagram we have recession of the other anions with corresponding extension of bicarbonate. The bicarbonate ion used in this process comes from the carbonic acid which the respiratory mechanism sustains in the plasma at a controlled level. In the last diagram reduction of base causes an equivalent reduction of bicarbonate. These changes in bicarbonate are not permitted to exert their full effect on reaction. As roughly indicated in the diagrams the respiratory mechanism undertakes to alter the normal carbonic acid concentration in the direction which will restore the normal carbonic acid-bicarbonate ratio. This respiratory defense, although it greatly limits change in reaction, usually falls considerably short of complete compensation for the bicarbonate change. So it is evident from the diagrams that study of the pathogenesis of acidosis or alkalosis must consist in first finding the alterations of the normal plasma structure which have caused the bicarbonate change and then explaining if we can the development of these defects in terms of the accompanying circumstances of disease. As you know, the morbid anatomy of the plasma structure is very diverse. Many conditions of disease may cause various distortions with resulting acidosis or alkalosis.

The other important physical property of the plasma, its osmotic pressure, is determined simply by the sum of the concentrations of the individual ions, and this is measured by the height of the diagram. The adjustable component, as we have just seen, is on the anion side and so it follows that the total base concentration will determine the total ionic concentration. This is illustrated in the last diagram which describes hypotonicity of the plasma produced by reduction of total base concentration. In the plasma more than 90% of total base is sodium, and so we find that the stability of the normal osmotic value of the plasma depends almost entirely on the accuracy of renal control of this one large component. So it is perhaps not surprising that the kidney has been given the assistance of an adrenal hormone in this important assignment. This total ionic concentration which the kidney sustains in the plasma establishes the level of osmotic pressure throughout the body fluids.

Now, besides total ionic concentration which determines their osmotic value, the body fluids have another overall dimension, volume. Presumably there is an optimal volume. It is evident however that preservation of the normal osmotic value has physiological priority. The kidney, so long as it is able to operate accurately, sustains the normal total ionic concentration at the cost if necessary of wide change in volume. If, for instance, pathological processes cause a loss of electrolytes the kidney removes a corresponding quantity of water. If water deficit is the primary event the kidney defends total ionic concentration by removing electrolytes. So we find in the presence of processes of dehydration a parallel loss of water and electrolytes. This has the important therapeutic corollary that body fluid deficits cannot be repaired by water alone.

This brings us to what will have to be a very brief discussion of the rationale of fluid therapy. We will consider only the situation in which there is urgent need for replacement of large losses of the body fluids. Our first premise is clearly defined. We must provide electrolytes along with water, and in those situations in which the patient is unable to accept fluids orally this is accomplished by subcutaneous or intravenous infusion of a suitable isotonic solution of electrolytes. This is an obvious and well established procedure, although we continue to debate what a suitable solution of electrolytes is. There is another requirement which is often neglected or inadequately met; the need for additional water to cover the obligatory expenditures by the body. To this end we use a solution of glucose. The services of glucose solution and of electrolyte solution are thus quite separate. We expect the water which we provide as glucose solution to be spent, whereas the water which we give along with the electrolytes we hope will be retained. This will not be the case unless the obligatory expenditures are completely covered. Moreover, besides the water which glucose solution supplies, the metabolism of glucose provides several physiological benefits which incidentally conserve the body fluids.

So it is evidently important to know how much water and glucose should be provided to cover the obligatory expenditures of water and to gain to a maximal extent the several benefits from glucose. This we may call the physiological requirement in fluid therapy, and we may note that, in contrast with the variable requirement for replacement of the body fluid losses, it should have a standard value for a subject at rest, and also it must have priority. In this necessarily brief discussion of fluid therapy, I will only undertake to define this requirement. In the course of studies on the life raft ration carried out over the war years in association with Dr. Allan Butler we had an unusual opportunity to measure its components. We were provided with healthy young adult subjects who were cheerfully willing to undergo periods of fasting and the much more severe experience of thirsting.

The measurements of the effects of glucose which produce conservation of the body fluids are recorded on this chart (Figure 4). In these experiments an ample intake of water by mouth was provided over a period of fasting and over subsequent periods during which glucose was given at several levels of intake. The upper section of the chart describes the well known protein sparing effect of glucose. The daily losses of body protein derived from measurement of nitrogen outgo in the urine are recorded additively. The lowermost line describes the progress of consumption of body protein across a 6-day period of fasting. By the end of the period this amounts to about 400 gm. For each gram of protein lost, 3 gm. of water are removed from the body in order to preserve the normal concentration of protein in cell fluid so that this loss of protein defines an accompanying loss of 1200 cc. of intracellular fluid. When an intake of 50 gm. of glucose daily is provided, the loss of body protein is considerably reduced. An intake of 100 gm. brings it to about one-half of the loss found for fasting. A larger intake provides very little further protection of body protein. So we can say that the maximal protein sparing effect of glucose is gained by providing a daily intake of 100 gm.

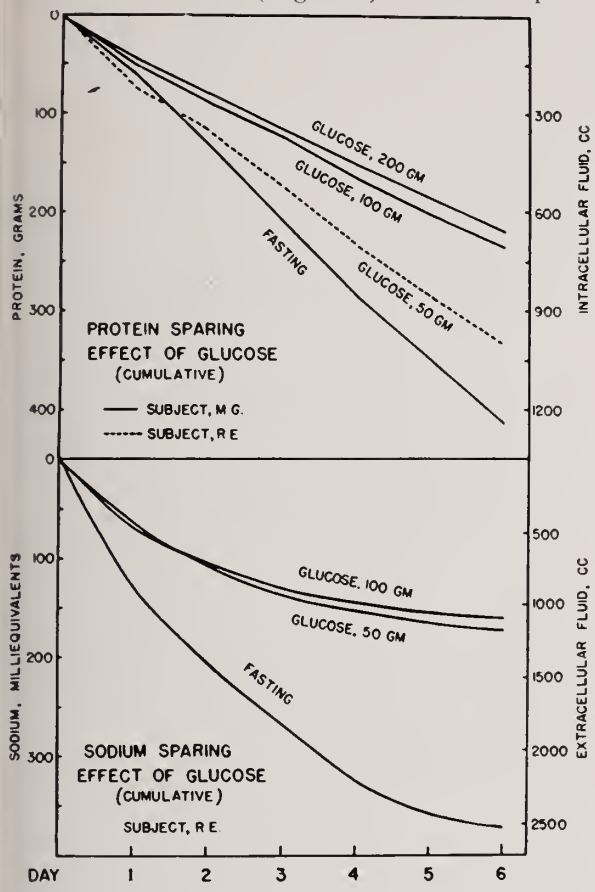


FIG. 4

The lower section of the chart shows an unexpected effect of glucose; a large sparing of the extracellular base sodium. Over the 6-day period of fasting the loss of sodium was about 400 millimols and defines a removal of about two and one-half liters of extracellular fluid. This loss is reduced by more than one-half by a daily intake of 100 gm. of glucose. Fifty grams is almost as effective. We are unable to explain this effect of glucose, but there it is and, as you see, it extensively conserves extracellular fluid.

Another important effect of glucose is prevention of ketosis which is a prominent feature of fasting and may cause acidosis of quite severe degree. This benefit is completely gained by an intake of 100 gm. daily.

Aside from these physiological effects, a very large elevation of morale was observed when glucose was given. The cheerfulness and sense of physical effectiveness of our subjects was in striking contrast with their unhappy lassitude during the fasting experiments.

Assuming that the same effects would be gained by providing glucose parenterally, these experiments define the requirement for glucose in fluid therapy as 100 gm. per day for an adult. We have next to decide how much water to give along with the glucose in order to cover the obligatory expenditures. There are two items of water outgo; the loss of water insensibly by way of the lungs and skin which has a fixed basal value and the water required by the kidney. Minimal renal expenditure of water is determined by the quantity of substances claiming removal and the maximal ability of the kidney to concentrate them in the urine. With a usual water intake under guidance of the sensation of thirst the kidney is provided with a great deal more water than the physiological minimal. These relationships are shown in the first section of this chart (Figure 5). The kidney's daily excretory assignment is measured as milliosmols, this being the physical

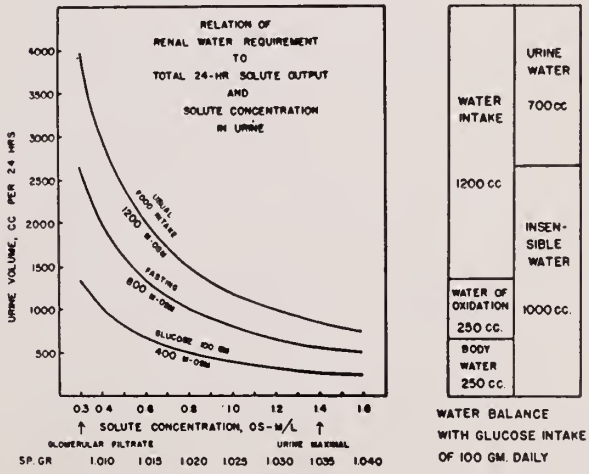


FIG. 5

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chemist's unit of measurement when he wishes to relate the quantities of various substances in a solution to its osmotic value. That is where the -os comes from. Under ordinary circumstances the kidney's daily load may be taken as about 1200 milliosmols. In our fasting experiments it was about 800. Glucose by its sparing effects brings it down to approximately 400. The ordinate of the chart measures the volume of urine required to remove these several loads over the physiological range of concentration of solutes, expressed as os-mols per liter, shown on the abscissa, extending from the concentration in glomerular filtrate which is the same as for the blood plasma, to maximal concentration which may be taken as 1.4 os-molar. For a patient subsisting on 100 gm. of glucose the volume required at a given solute concentration is, because of the smaller load, only one-third as large as under ordinary circumstances. If this load is removed at maximal concentration, the renal water requirement is about 300 cc. It is fair enough to use this minimal quantity as the renal water allowance for a castaway on an emergency ration containing only carbohydrate but for a bed patient, who can easily be provided with water, there is no need to demand of the kidneys the osmotic work which maximal concentration requires. At a usual concentration, which may be taken as 0.6 osmolar, the water requirement is about 700 cc.

The components of the water exchange for a patient receiving 100 gm. of glucose are assembled in the diagram. We found for our subjects at rest an average daily insensible loss of about 950 cc. so we may allow one liter for this expenditure. To cover the outgo column, there is water available within the body to the extent of about 500 cc. This is composed of the loss of body water which is beyond the sparing effect of glucose and also water produced by the oxidation of body fat, protein and the glucose which we have provided. So by difference we find that the quantity of water which we should provide along with 100 gm. of glucose in order to sustain the water balance of the body is defined as 1200 cc. If we use a 5% solution of glucose, 2 liters will be required; and so we will, according to our estimation, provide a large surplus of water. It is not however an inordinate surplus. Moreover it may be importantly serviceable in the event of large extension of the insensible loss by sweating produced by the frequent error of overcovering our very sick patients. So we may accept 2 liters of 5% glucose solution as a convenient statement of what we are calling the physiological requirement in fluid therapy.

I have wished to emphasize the importance of this requirement because I find that its priority is often not recognized. As evidence I may cite a procedure which is completely wrong. The provision of glucose by just dissolving it in the electrolyte solution. Five per cent glucose in saline is quite commonly used. The benefits from the metabolism of glucose will of course be gained, but no surplus water is provided and so the obligatory expenditures will have to be covered by water taken from the electrolyte solution and the kidney will then be required to remove a corresponding quantity of the electrolytes in order to preserve their normal concentrations in the blood plasma. A large part of the electrolyte solution given to replace body fluid deficits will thus be lost. Obviously this does not make sense. I feel that I should apologize to this audience for even mentioning such an obvious fallacy.

It is appropriate that any discussion of the body fluids should close on a note of admiration of the kidney which is mainly responsible for their integrity. The chart provides opportunity for praise of this remarkable organ. We note the enormous economy of water expenditure that has been gained by the mamalian kidney's ability to secrete urine at a solute concentration which is about five times that of the blood plasma. The curves describe an interesting feature of this economy; it follows a path of diminishing return. For instance, for the 1200 milliosmol load, urine volume required at the concentration of glomerular filtrate is 4 liters. By increasing concentration only as far as 0.6 osmolar, urine volume is reduced to 2 liters. To bring volume down to 1 liter, concentration must be carried all the way to 1.2 osmolar, and beyond this point reduction of volume by further increase in concentration becomes almost negligible. We are told that maximal concentration is determined by a limit to the ability of the kidney to do osmotic work. This may be so, but a more respectful statement would be that the kidney stops concentrating solutes at the point beyond which further expenditure of osmotic work would be wasted. In other words, the end point of renal effort is just where it reasonably should be.

The charts in this paper are reproduced from the author's lecture syllabus, Chemical Anatomy, Physiology and Pathology of Extracellular Fluid, published by the Harvard University Press.

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MEDICINE'S CONCERN ABOUT LICENSURE OF MEDICAL RECORD LIBRARIANS*

CHARLES L. FARRELL, M.D.

The Author. *Charles L. Farrell, M.D., Pawtucket Rhode Island, Chairman, Committee on Public Policy and Relations, Rhode Island Medical Society; Delegate, American Medical Association.*

HUMAN SOCIETIES come under the influence of great tides of thought that run beneath the surface. After a while, these powerful streams of opinion affect certain segments "en masse" without individuals in the mass being aware of the direction in which they are going.

Up to a certain point it is possible to resist these tides — and even stop and reverse them — but there comes a time when they are so strong that we lose the power of decision over them and must rush on and on to the predetermined consequences.

You, who are interested in the licensure and educational training of medical record librarians, are moving along under the dominance of such a tide; and unless you make a determined attempt to control your destiny, you may rush headlong into a future of restricted activity which you, as pioneers in a new, and for many of you an original field — do not by any standard deserve.

It is a typical American trait to invent a product to fit a given situation — to produce a better product than anyone else and then to constantly improve the quality of that product.

Unfortunately, however, in our zeal for higher and higher standards we are prone to embellish the product with commendable but unnecessary furbelows, and to eventually so elevate its sphere of influence that another and secondary product must be made to fill the gap left vacant by the elevation of the first to higher and special fields.

The secondary product then fills the need originally met by the first — and usually at a *lower* standard than that displayed by the original.

Time was, in Medicine, that the general practitioner handled the ills of all the people — but because a certain but nonetheless limited percentage of his cases required special skills — the role of the specialist was created. Now — the majority of medical school graduates tend to limit their practice exclusively to certain fields — thus creating a licensure problem and the need for special Boards of Certification. This in turn limits the number of workers in the field of general practice — leaving the rural and smaller communities a diminished supply of that backbone of medical care — the family doctor. This gap is then filled with secondary practitioners and cultists who attempt to meet the community needs once filled by the general practitioner of medicine. All of which results in a dilution of the quality of medical care available in the areas of greatest need and raises the cost to the ultimate consumer.

In the ancillary services we have a repetition of the process. The chiropodist who once filled a definite need for minor and inexpensive services requiring mostly technical and limited training for effectivity — has gradually expanded by increasing educational requirements until these prerequisites limit the field and increase the cost of education— all of which tends to raise the cost to the ultimate consumer and decrease the number of practitioners. There is no reason to demand that the skill required to immerse a pedal extremity in aqua pura be contingent on an ability to discourse on the philosophy of Aristotle or the drama of Euripides.

In the field of Nursing — the educational expansion has created a group of administrators who, though efficient and learned, leave a gap in the physical care of the patient which in turn is filled by secondary practitioners such as nurses' aides or practical nurses.

Hospitals in turn have followed the trend, and instead of serving the people of the community by placing the hospital facilities at the disposal of the duly licensed medical practitioners in the area, they have — under the guise of elevating standards — required Certification as a basis for services — even in the ordinary fields of endeavor. The hospital was originally a charitable institution operated by local citizens with philanthropic motives. This is still true in some smaller communities and with the religious institutions, but in altogether too many instances the present hospital in the urban area is in Big Business and operated as such. Of late years they have turned to the state for tax money to meet their deficits acquired, they claim, from treating indigent patients.

I am unalterably opposed to state or bureaucratic

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* Presented at the Annual Meeting of the Rhode Island Association of Medical Record Librarians held in Providence, Rhode Island, on May 10, 1950.

control but I am equally sure that *IF* hospitals are going to ask the state for money to meet deficits — money which is collected from taxes levied on ALL citizens — then the State has a right and even a duty to inquire as to the "modus operandi" of such hospitals and to further inquire whether or not the hospital practices proper economies — avoids extravagances and utilizes usually accepted business procedure. If state tax funds are to be given hospitals, are not these hospitals in turn obligated to admit all tax payers as patients and permit them to be served by their own physicians, who in turn are likewise taxpayers? It is rank hypocrisy to talk about "Free choice of doctor" when private hospital corporations limit staff membership and even restrict the freedom of its own staff members.

You are fully cognizant of the development of formalized training for medical record librarians and the establishment of your association because of the need for standardization of clinical records.

The prime function of your training then, is to prepare you to keep medical records in such a manner that they may be used in the care of the patient — the compilation of statistics and the development of reports on which medical progress is predicated. In order to properly fill this function a specialized training is necessary and as much more cultural educational background as is possible without, however, so expanding the curriculum as to increase the cost of education in that many able candidates are eliminated — the overall expense increased — thus resulting in turn in higher salaried personnel with limitation of the field.

The success of any educational program is measured by the ability of its licentiates to effectively meet the demands of their environment. If the established and experienced medical record librarians in this state are able to meet the challenge of our modern hospital — and I know they are — they then constitute the best proof that the road they have travelled has been practical and effective so that prompt and proper recognition of such experience and training should be immediately forthcoming by accrediting bodies.

It is an established rule of Law that no licensure regulations are retroactive or restrictive to those already licensed.

Too often, however, we find that special interests in various fields have, with ulterior motives, written rules and regulations designed to curtail and restrict those already in practice in favor of those yet to come. The deplorable feature of this type of thinking is that it establishes precedents which may boomerang later on.

Those — who today feel that they possess the highest and the best of educational qualifications will soon discover that ere they have practiced very long — a new generation with still higher and more exacting standards enters the field with demands for stricter and tighter controls.

Then we are faced with the recurring necessity of inaugurating a secondary group to do the basic work for which the original group was primarily designed; but which will have become by now— administrative and executive only.

Do you realize that the Medical Secretaries are already on the horizon and do you appreciate the threat of a secondary worker in your field? Do you further appreciate that the field of activity encompassed by medical record librarians was developed and brought to its present state of maturity largely through the efforts of technically trained young women who had the vision to realize the importance of this work?

It is indeed a great tribute to those pioneers that today educational institutions look upon this field as fertile soil for their endeavors — but as they did not initiate this branch of library science, neither should the conferring of belated attention by education be permitted to eliminate or curtail the medical record librarians who through sheer technical skill and natural ability have contributed so materially to the development of this science.

I was present at the hearing before the Council on Medical Education and Hospitals of the American Medical Association when the Essentials of an Acceptable School for Medical Record Librarians was discussed.

The hearing developed unmistakable evidence that the Council did not condition its thinking along the lines adopted by certain advocates of a counter proposal which would, in effect, have barred or at least made it extremely difficult for, pioneers in this field of library science to become Directors of Schools of Training.

At present, in order to be considered for a Director of a Training School — a medical record librarian may be eligible if she has eight years' experience in charge of a medical record library in an approved hospital — and

New Directors appointed after January 1, 1954,
Should have an academic degree from an approved college or university with courses in psychology and teaching methods, plus graduation from an approved medical record librarian's school, and
two years *in charge* of the medical record library in an approved hospital.

There were forces at work which would have made the above requirements mandatory but I am sure the Council was wise in leaving the wording optional in the use of *Should* instead of *Must*.

I therefore urge you to mark well the progress of the tides that affect your welfare, and I believe that your interests will be best served by continuing to press for the adoption of your proposed amend-

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AMERICAN DEMOCRACY ON TRIAL*

BAIRD H. MARKHAM

The Author, *Baird H. Markham, of New York City, Director, American Petroleum Industries Committee of the American Petroleum Institute.*

ANY MAN would feel honored by an invitation to address this distinguished conference. Speaking for myself, I can say that I have approached this occasion in a spirit of humility. You have honored me, but you have also flattered me by this invitation. For with an audience of such wide learning, the chance is slight that I can tell you anything you don't already know.

But — if I can help you to see in even a little different light the things you do know — at least I shall not have wasted your time or presumed upon your hospitality.

My field — the petroleum industry — is far removed from yours. But my specialty — organization — must also be of great concern to you — or you would not be here.

Knowing how important it is for doctors to have a medical association, you will understand why oil men must also have an organization to promote petroleum research — to supply the layman with facts about the oil industry — and to represent the industry in its broad relations with the public and with government. In short, oil men, like doctors, must have an organization which can serve them and which they — as individuals — can serve.

I should like to emphasize that latter point — an organization which they — as individuals — can serve. Theodore Roosevelt once said: "Every man should devote some part of his time to the building up of the industry or profession of which he is a part."

Is this the counsel of idealism? Is it visionary to suggest that every man owes his business or profession some unselfish time, some time devoted strictly to the promotion of that profession — as distinguished from mere self-promotion?

On the contrary, in our unsettled era this is the most practical and hard-headed advice which can be given. Nothing can stand still these days, and if men do not work to improve their business or profession, then it will surely slip down — and drag them with it.

Importance of Organization

To the best of my knowledge just about every business, industry, and profession in this country is organized today. People have not formed these organizations just because they are sociable and welcome a chance to get together and talk shop. They have organized because they have learned there is no practical substitute for organization.

The doctors of America discovered the importance of organization in 1847 and formed the American Medical Association. This, of course, was long before the founding of the American Petroleum Institute. In fact, it was more than a decade before the petroleum industry itself came into existence. But by 1919 oil men, too, felt the need for a medium by which they could coordinate their individual efforts for the betterment of their industry. And so the American Petroleum Institute was formed.

I shall not boast to you about the accomplishments of the American Petroleum Institute, proud as I am of them. Nor shall I deny that our organization has sometimes erred in judgment. I do not claim we are perfect — or that the industry we serve is perfect.

Men in the oil business have made mistakes. They have been misrepresented and misunderstood. Unfortunately, these mistakes and misunderstandings have been widely publicized in a world which hears little about the quiet achievements of the great majority of oil men whose activities constantly follow constructive lines.

When an individual of prominence commits a blunder it is front-page news. But when an entire industry makes tremendous technical strides within a few decades, produces a continuously improved product at a reasonable price, meets the challenges of global war, and does not fail the equally great challenges of an expanding post-war economy — If that story is told at all, it is told in a paragraph of two or the inside pages.

You have the same problem in your profession.

I suppose there are few men who lead more dedicated lives than the typical country doctors of our

continued on next page

* Presented before the Sixth Annual Conference of Presidents and Other Officers of State Medical Associations, at San Francisco, California, June 25, 1950.

land. Yet, barring an event like the birth of quintuplets, how often is the service of the country doctor known outside the circle of his own grateful patients? The same is true of the skilled surgeons and specialists of our great cities. Miracles in medicine are expected of these men, and when performed are treated as matters of simple routine.

There is danger in this situation — grave danger — for the medical profession. Even worse — there is danger to the American way of life itself.

Today we say democracy — American democracy — is on trial. Too many are eager to testify for the prosecution: too few for the defense. Volumes are written on our mistakes, our shortcomings, our failures, our weaknesses. But our strength, our achievements, our greatness, our service — these are taken for granted.

Those on the side of the prosecution — those who wish to paint America black — wield a mighty brush, make no mistake. They know how to magnify every flaw out of all proportion to its size, and they know how to minimize every worthy thing we have done and are doing. It is their aim to becloud our vision of the future by cutting us off from the American past.

And in these ceaseless efforts they are succeeding to an extent which we cannot view with complacency. For they are clever. They are united in their aims — disciplined in their methods. In short, they are organized.

As a fundamental part of their strategy, these agitators insinuate that the individual must be regulated because he cannot be trusted.

Yes — this is, at bottom, the theory of those who would change — drastically change — our form of government.

The Record of Democracy

Now let us think about the opposite theory. Let's turn back to the time our country was founded. What is the feature of our Constitution which electrified the world, raised the spirits of the downtrodden everywhere, and caused tyrants to tremble? Simply the implied conviction that a citizen of our country is not a rascal. Neither is he a fool. He is, on the contrary, a man of essential goodness, capable of governing himself — and thus of playing a part in the government of his country.

In 1789 this was the most radical of all political theories. But on the basis of developments since then, I submit it has proven to be a workable theory.

We have blundered at times. We have stumbled and we have slipped. But we have always managed to keep our form of government in the midst of a world torn with revolution and littered with the ruins of fallen empires. Of late we have even been able to contribute very materially to the support of those governments which pronounce our political procedure unsound and impractical.

The critics, the prosecutors, the detractors of the American way have no answer for this record of achievement — so they choose to ignore it or — still worse — to falsify it.

They picture the free enterprisers of our past — our pioneer Americans — as ruthless barbarians — without principle, without mercy. Does this portrait bear any resemblance to the men it represents?

Was selfishness, greed, treachery, the stamp of the pioneer who plodded the overland trail to California, to Oregon or to the points between? Does the record show that our pioneers lived under the jungle code of every man for himself? Indeed, no!

Cooperation among individuals — organization if you will — attained its highest expression among the wagon trains on the Overland Trail, among the early settlers of the prairies, among the ranchers and herders, wild-catters and gold-seekers of the pioneer West. To be sure, this cooperation was not enforced with directives. It was not planned by a Washington bureau. It did not involve the filling out of notarized forms. It was not recorded and itemized in statistics and surveys. It simply existed everywhere, and was expected everywhere.

The cooperation of the pioneers was the voluntary act of resourceful individualists, not the empty minded obedience of cringing collectivists. For our pioneers were the kind of people who could follow the path of duty without the aid of road maps supplied by some Washington bureau.

In the strange new world these pioneers elected to invade, all the forces of nature were pitted against them. In the desert, in the mountains, on the trackless plains — death by starvation, by thirst, by flood and fire, by blizzard and cyclone, were daily threats.

Who could hope to go it alone in such an environment? Who could take an abstract view of the subject of organization or calmly debate the worth of cooperation with his neighbors? Then it was organize or die, cooperate or perish.

It is still that way today, but in a different sense — if we could only see it. For the death of our democratic way of life would mean the death of each of us — or, at least, a life so bitter that total extinction would come as a release.

Some critics tell us we cannot live now as our ancestors did because today life is more difficult. Voluntary cooperation won't work any more, they say, because we can't have security now unless the government gives it to us.

But, may I ask, what kind of security did the pioneers of America have? Who guaranteed them against the risks of famine and drought, of storm and fire, of blizzard and cyclone, of Indian raid and outlaw gang? What kind of security did they have except the security of trusting in the cooperation

of their neighbors as neighbors trusted in their cooperation?

Voluntary Cooperation of Free Men

Do the critics of our way of life maintain that we are an altogether different breed from these Americans of a century ago? And if they do — is it true?

The record of the recent war tells me that the American people have not changed. They have the same courage, the same ideals — even though sometimes they have been misled as how best to attain them.

And I know our democracy can win through in its present trial in the same way our pioneer ancestors met all the trials of their daily life — by the voluntary cooperation of free men.

What better vehicle is there for this voluntary cooperation than such existing trade and professional associations as, just for example, the American Medical Association and the American Petroleum Institute?

Let us make no mistake about it — there is work to be done, and to be done now. We require no ringing of an alarm to tell us that. Each of us is now in as great a predicament as the pioneer who saw the prairie fire raging on every side of his cabin — or heard the shrill war whoop of Indian raiders.

The crisis is not coming. The crisis is here.

Let us consider the nature of this crisis, since it affects your profession and my industry, and the freedom of all of us.

From its very beginnings, scientific medicine has had to wage war on superstition and quackery in the treatment of human ills. Through your medical associations you have fought this dangerous superstition with valor and with marked success. You have exposed and checked the cancer quack, the glorified witch doctor, the peddlers of fake cure-alls, and others who fatten on human suffering.

But today there is another quack abroad in this country — a quack no less dangerous to those who value liberty as we value life. I refer to the quack in the field of economics.

We who are familiar with political economy know that enterprise, investment, production, and employment cannot be encouraged by taxing industry down to its blood, bones, and marrow or by regulating it to despair. We know, too, that government has no independent source of wealth; that it can spend only what it takes from the people. We also know that deficit financing is just an illusion, like those fake hair-growing lotions which, by tinting the fluff on a bald man's pate, give him the brief impression that he is cultivating a new set of lush and curly locks.

We know these truths, but what good does just knowing them do? Of what use is a sound diagnosis if no attempt is made to treat the disease?

Economic Frauds Must Be Exposed

I would say that one of the most important tasks of American industry today is to spread economic truths to a public that is being drugged by economic fallacies. I would say that American industry must set about exposing economic frauds just as vigorously as your associations expose medical frauds.

In addition, both industry and the professions should make it a basic function to tell the story of their achievements to the American people. Let us face the fact that the slanders now being hurled against business and the professions have for their purpose the destruction of the American way of life. The authors of these slanders plan to effect this overthrow not by force and violence, but by the slow poison of propaganda. Yes, propaganda against the oil industry, against the medical profession, against private enterprise in all its forms.

This propaganda must be answered, vigorously and forcefully, with the truth — with the record of what we have done, and are doing, for the American people. Remember, if the private-enterprise system is overthrown, my business and your profession will be among the first to go because they are among the most solid props of the American system. Deprive us of freedom, and everyone's freedom is on the way out. This should explain why abuse and attack are directed at our activities by those who seek to crush, destroy, and root out democracy and the entire system of American free enterprise.

What more can we do now to meet the crisis which confronts your profession and my business? I hesitate to mention one except that it is so sadly neglected. This is the participation of all supporters of the private-enterprise system — of businessmen and professional men — in the affairs of their government on a local, state, and national basis. Not merely on issues directly affecting their own business or profession, but on all issues which, for better or worse, affect the future of our cherished heritage. This means, first, voting at all elections. Too many business and professional men neglect this elemental duty and privilege. But this is not enough. During, after, and between elections we should actively support those who are working to strengthen and defend our system — and just as vigorously we should oppose, and defeat, those who work against us.

There is only one way to save economic freedom in this country, and that is for each of us to be an active member of the rescue party. Which brings me to another fundamental obligation. It is not enough merely to tell the people what we believe.

continued on next page

We must show them what we believe — by our actions, by our attitude, by our display of faith and interest in the system under which we live.

The Responsibilities of the Individual

If each of us will accept the challenge that the public reputation of his profession depends to a very large extent upon his own personal conduct in that profession, then the agitators and the critics of the American way will soon be left with no scandals to proclaim.

Like it or not, we are judged by generalities — not by painstaking research. The average man judges the medical profession by the doctors he has known. He judges the oil industry by the oil men he has met.

And in the case of the activities of your profession and of the oil industry, the importance of receiving a favorable judgment cannot be overemphasized. For we are both in an exposed position.

Industry, transportation, business, the military machine must have oil. Progress depends on oil and all mechanical activity requires lubrication.

As for you — your profession means life — and that statement requires no elaboration.

Should we oil men fall down on our job, and America's industrial machine falter or fail for lack of fuel — I dread to think of the criticism that would follow. And I dread it the more because this criticism would be deserved. Regardless of the circumstances, too many people depend upon the oil industry for us to have any excuse for failure.

Yes, oil must always be available to the American people, when they need it, where they need it. And medical care must be available, too. Your problems, your procedure, your objectives are different from ours, but your duty is the same. Your duty is the same with this exception — our work is concerned with material things, but yours with human life itself. Therefore, though our responsibility is great, yours is greater still. Yours is the greatest of all responsibilities.

How is this tremendous responsibility to be met? Let's just reflect for a moment on what is being done to meet it now. What is the result of the present voluntary cooperation of the American medical profession and the American public? Anyone who reads the record of recent years will find inscribed therein an account of humane progress unsurpassed in all the annals of civilization.

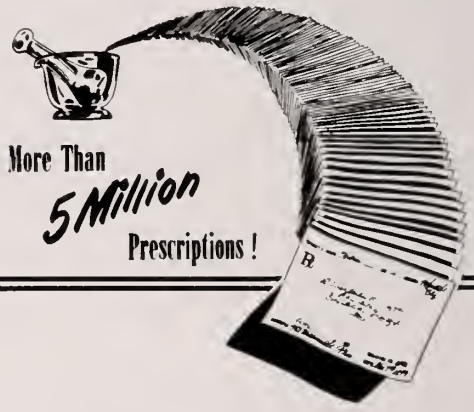
I am thinking now of the growth of just one voluntary health plan — the Blue Cross — from fewer than 12,000 members in 1934 to more than 30,000,000 Americans today. I am thinking of the employee medical programs which are now being provided by many corporations. I am thinking of the private organizations which have been formed to fight cancer, heart disease, tuberculosis, polio — and many other ills which terrorize society. I am thinking of the blood banks and the mass chest X-ray programs.

Of course, these are inadequate. Of course, they are only a beginning on what needs to be done — but what a beginning! The time is now in sight when every American can feel assured that no barrier of region or of means separates him from the best of medical care. And how much more to your credit and to ours if we can achieve this ultimate ideal in the American way — the way of voluntary cooperation among free men.

I have said democracy is on trial. Actually, it is we who are on trial. If we succeed in fulfilling the responsibility fate has placed upon us, I do not see how democracy can fail. For, after all, we — each of us — are the parts which make up democracy. And if the parts are sound and true, the whole must endure.

In the second century, a young pagan of the Roman Empire noted the strangely different attitude of members of the rising Christian sect and observed: "See how these Christians love one another." Soon he too was converted to Christianity — not by sermons and tracts, but by example. He did not have to be lectured on what the Christians believed. He saw for himself what they believed — and how faithfully they practiced their belief.

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DYNAMIC DEMOCRACY

"... Why, the great majority of my friends — not all of them ... confuse dynamic democracy with socialism ..."

Thus did the majority leader of the House of Representatives in Congress defend the President's reorganization plan No. 27 to create a department of health, education and security against the attacks of those Congressmen who pointed out in no uncertain terms the bureaucratic and socialistic aims imbedded in the proposed legislation. Dynamic democracy or socialism, the two now become synonymous if we accept the majority leader's explanations, was defeated by a 249 to 71 vote.

Among the 71 who supported the President's program of "Dynamic Democracy," we regret to report, was Congressman Aime J. Forand, Congressman from the first Rhode Island district.

Reorganization Plan No. 27, submitted by President Truman on May 31, would have established a Department of Health, Education, and Security. All agencies of the Federal Security Agency, together with their respective functions, records, property, personnel, etc. would be transferred to the new Department.

The Department would be headed by a Secretary of Health, Education, and Security to be appointed by the President with the consent of the Senate and to whom the functions of the present Federal Security Administrator (Oscar Ewing) would be transferred. Three major bureaus in the new Department would have corresponded to the three major units of the present Federal Security Agency.

The Plan differed from the reorganization plan No. 1 that was rejected by the Senate chiefly in a change of the name of the new department, and in the retention of autonomous powers of the Public Health Service and the Office of Education.

The only point at which Plan No. 27 touched the program of the Hoover Commission was in its creation of a new department, but that department would *not* be that which was recommended by the Hoover Commission. A major point of difference from the Hoover Commission program was the inclusion of health functions in a department with education and social welfare.

The American Medical Association, as did the Rhode Island Medical Society, opposed Plan No. 27. Reasons were many. The plan was in direct conflict with the recommendations of the Hoover Commission: it would render more difficult or impossible the creation of a department of Health at any future time; it would not have been a reorganization of administration, but a renaming of an agency admittedly faulty in setup; it would point toward eventual Federal domination of our voluntary hospital system; it would create a master organization ready and anxious to take over administration of a national compulsory health insurance program, and it would place the administration of the Nation's health activities in the hands of a politically appointed secretary with no professional qualifications.

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But read what some of the Congressmen had to say about this socialistic — pardon us, "Dynamic Democracy" — program —

Hon. R. F. Rich, of Pennsylvania —

". . . It is about time that we took an inventory here. This thing is so terribly bad that the American people will wake up in a short time and they will find out that instead of having a country where we have our freedom and our liberty and independence, we will have a land of socialism and a land of dictatorship."

Hon. L. C. Arends, of Illinois —

"Instead of reducing expenditures this plan will lead to increased spending. Instead of less government, this plan proposes more government. Instead of promoting efficiency this plan will bring about political control in those fields, such as education and public health, where there should be a minimum of such control."

". . . There is hardly any doubt that Mr. Ewing will use the prestige and influence of his new rank of Secretary in the President's cabinet to promote the socialized medicine program he has been vigorously advocating as Federal Security Administrator."

Hon. C. D. Kearns, of Pennsylvania —

"I am becoming a little fed up with plans. There are plans for the farmer; there are plans for labor; there are plans for little business; there are plans for minority groups — there are plans for every single group which seems to hold promise of a block of votes."

"Plan No. 27 is not good for the public school system of the United States. It gives to the Secretary of Health, Education and Security the authority to transfer United States Office of Education personnel, records, and funds. In short, plan No. 27 puts the present administration on top of the budget and the personnel of the United States Office of Education."

Hon. C. J. Brown, of Ohio —

"We found some strange things in our studies of the Federal Security Agency.

"We also found a great deal of inefficiency, waste, and extravagance. Our findings (The Hoover Commission) have been fully supported in just the last 2 or 3 weeks, by a report of a subcommittee of the House Committee on Post Office and Civil Service . . ."

"For instance, we found in one social security office or division several thousand Government employees patiently and faithfully keeping records which the law had not required to be kept for many years. There were five or six thousand employees who were not needed at all."

But all this, the majority leader of the House, Congressman J. W. McCormack of Massachusetts, apparently considers "dynamic democracy," and not socialism.

From where we sit on the sideline we venture the opinion that the real dynamic Democracy in Congress was demonstrated by the 249 Congressmen who denounced Plan No. 27 for the political promotion scheme it was.

HOSPITALS AND THE PRACTICE OF MEDICINE

The announcement by Dr. Charles J. Ashworth, president of the Rhode Island Medical Society, that Dr. Elmer Hess, author of the Hess Report on hospitals and the practice of medicine, will address the Society at its midwinter meeting in Woonsocket on December 13th should interest every physician in this area. Certainly the meeting will draw an attendance of many doctors from our neighboring states.

Physicians in their relationships with hospitals must be guided not only by the laws of the various states, but also by the principles of medical ethics of the American Medical Association. The state laws for the most part rule as illegal the corporate practice of medicine. The classic example of such illegal practice given by the courts is the instance in which a corporation hires a professional man and then sells his services to the public on a fee basis for the profit of the corporation.

In its code of ethics the AMA sets forth that

"a physician should not dispose of his professional attainments or services to any hospital, law body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

Another matter brought out in the Hess report is that of the principles of relationship between hospitals, radiologists, anesthetists, and pathologists. These principles emphasize that the primary obligation of both physicians and hospitals is to serve the best interest of the patients. This leads to the fundamental principle that the decision as to the ethical or unethical nature of practice must be based on the ultimate effect for good or ill on the public as a whole. Thus, in the final analysis local conditions must decide the various arrangements and conditions of practice in reference to both hospital facilities and medical personnel and their relationships, with the patient as the prime beneficiary.

In its report to the Board of Trustees of the AMA the Committee on Hospitals and the Practice of Medicine pointed out that

"there can be no exploitation of the doctor or of the hospital if everyone concerned in management and on the professional staff will work together to supply the greatest possible good quality medical and hospital services of the public. In any given controversy every effort should be made to settle the matter at the staff-management level. In case of failure to settle the controversy at this level, the assistance of county (or district) medical society should be requested. If, then, it cannot be resolved it should be submitted to a committee of the state medical society for advice and recommendation. If problems cannot be solved ... the Constitution and By-Laws of the American Medical Association provides that ... the Judicial Council may, at its discretion, investigate general professional conditions ... and make such recommendations to the House of Delegates or the constituent association as it deems necessary."

The House of Delegates of our Society has already given support to the establishment of district committees as well as a state committee on hospital and professional relations. Several of the district societies have already named their committees, the chairman of each to be a member of the state society group. Those district societies that have not acted on this matter should do so in order that the proper mechanism may be established to improve the physician-hospital patient relationships.

Not publicized widely, but nevertheless significantly noted in the report adopted by the AMA delegates as submitted by the committee, were some noteworthy suggestions offered as additional guides to physicians, county medical societies, and state medical associations, as follows:

1. That the costs of medical services rendered in hospitals be separated from the non-medical costs, as can be done by existing and accepted methods of cost accounting, and that they appear thus separated on the statement submitted to the patient.
2. That a physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Contrariwise the physician should not exploit the hospital. It is the sense of this Committee that neither hospital nor physician rendering the service shall exploit the patient or each other.
3. That fees for medical services which are collected by a hospital should be established by joint action of a representative committee of the staff to include the head of the department, and the administrator and the governing body of the hospital.
4. That the basis of financial arrangement between hospital and physician may be salary, commission, fees, or such other method as will best meet the local situation, consonant with the principles of medical ethics and with due regard to the needs of the patient, the community, the hospital and the physician.

PROPAGANDA

THE SOCIAL PLANNERS have been in the forefront in condemning the national education campaign of the American Medical Association. In spite of all the name calling, however, we have yet to read any sound refutation of the facts presented by the AMA. The educational campaign has been aimed at one general purpose – get the true story to the people of the country in order to counteract the propaganda of the political and socialistic groups who use the cry of government health insurance as a means to advance their own selfish interests.

The physicians of America would welcome, and we are sure every citizen would, factual presentations devoid of emotional arguments regarding any national issue, whether it be compulsory health insurance or anything else. To prove their belief the physicians have carried on their educational campaign, distributing literature that will stand up against criticism as to the validity of its content.

The best proof that the doctors' educational campaign has won approval is evidenced by the attempt now of the Democratic National Committee to flood the country with its booklet entitled "Better Medical Care that YOU Can Afford." This booklet subtly uses picture drawings and generalizations in its captions to win support for the Democratic party politicians by offering as bait a supposedly low cost compulsory health insurance program.

The brochure certainly wanders from the path of fact and truth when it compares government controlled health insurance through taxation with accident and health insurance as the people of this country understand that type of voluntary coverage.

One of the most damning parts of the booklet is the statement that "No worker would pay more than $6 a month." This is both misleading, and downright false in its implication. No mention is made of the increase in general taxes since the

continued on next page

proposal calls for use of general tax funds to meet any deficiencies. Likewise, the statement that the worker will be taxed only 1½% of his earnings does not carry the additional warning that in subsequent years the tax may be increased.

The Pawtucket Medical Association has taken a definite stand on the issuance of this political booklet of misstatements in letters to the Rhode Island members of Congress. The other district societies will do well to let local, state, and federal officeholders know that the use of such propaganda in this State will meet a strong counter-attack from the physicians of their respective areas.

Compulsory health insurance is not a part of the Democratic National party's platform. The endorsement of President Truman's plan by the national committee was not a unanimous decision. The sale and distribution of propaganda by the national committee to service its own personal aims should prove revolting to every follower of the Democratic Party in Rhode Island.

THE CHAPIN ORATION

We are pleased to print in this number of the Journal the Chapin Oration delivered at the annual meeting of the Society by Dr. James L. Gamble of the Harvard Medical School.

Physical chemistry has played an increasingly large part in medicine during the last half century. We think it is safe to say that up to that time even many of the leaders of medicine had slight knowledge of chemistry. Lawrence Henderson was one of the pioneers in this change over, and we have heard him characterized as a philosopher in chemistry. Dr. Gamble was one of the young men who early recognized the importance of the new trend, and his work through all these years has been concentrated to a large extent on chemical problems particularly as they are related to the body fluids.

He has not allowed himself to take merely close-up views of many minor details but relates it all to the development of animal life through the geological epochs. In talking to us, he set himself the difficult task of presenting in a simplified yet intelligent manner, an over all picture of the slow development of the body chemistry. He has refrained from giving us a lot of details which some of us would be inadequate to comprehend.

We feel that Dr. Tom Spies adopted a somewhat similar method when he discussed vitamins in his Oration last year. Despite the lucidity of Dr. Gamble's paper, it is not such that it is easy to comprehend at a single hearing. We think that you will be entertained as well as instructed if you read it.



Peter Pineo Chase, M.D., (left) President of the Rhode Island Medical Society, 1949-50, views the Dr. Charles V. Chapin Medal with the 1950 recipient, Dr. Gamble of Boston.

MEDICINE'S CONCERN ABOUT LICENSURE OF MEDICAL RECORD LIBRARIANS

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ment to the Constitution and By-laws of the American Association of Medical Record Librarians in order to effectively guard your interests after 1954.

The A. M. A. Council on Medical Education and Hospitals will be unlikely to make any further changes for some time and I believe that they consider it likely that any one of you now possessing the qualifications to be a Director of a school will have ample time to consummate that desire, if ever, in the period remaining before more stringent rules apply.

I have been closely associated with medical licensure and I am quite in accord with high and rigid standards so long as they provide for the inclusion of those already licensed and the protection of the rights already enjoyed.

Medicine has a task ahead — to restore the prestige of the general practitioner — to find a place for him on his local hospital staff — and to see to it that the Specialist is a true Specialist — not just an exclusionist.

Nursing and the ancillary services also need to watch the trends and not allow the pendulum to swing too far. The welfare of the public demands it. *We can't have all generals in the army of health care.*

You have a problem in controlling the tides that engulf you, but I am sure that by concerted and determined effort you will control your destiny, and I wish you well.

"Of 428 cases [of seasonal rhinitis and perennial rhinitis of allergic origin], 60% to 76% were benefited."

NOTE: A table, listing the results obtained in hay fever, shows that Hydryllin was used by ninety-seven patients and that 73 per cent experienced from 50 to 100 per cent benefit.

Gay, L. N.; Landau, S. W.; Carliner, P. E.; Davidson, N. S.; Furstenberg, F. F.; Herman, N. B.; Nelson, W. H.; Parsons, J. W., and Winkenwerder, W. W.: Comparative Study of Antihistamine Substances: III. Clinical Observations, Bull. Johns Hopkins Hospital 83:356 (Oct.) 1948.

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THE AMERICAN MEDICAL ASSOCIATION

Report of Delegate to the Annual Sessions of the American Medical Association at San Francisco, June, 1950

THE American Medical Association held its 1950 Annual Convention at San Francisco, California, June 26 to 30. Over ten thousand physicians attended the convention; nine physicians were registered from Rhode Island.

Your delegate attended all sessions of the House of Delegates, and the alternate delegate and vice-president of the State Society attended the important sessions of the House and several Reference Committee meetings. Your delegate and alternate also attended the round-table conference on legal matters by the counsels of the various state societies of the AMA.

Some highlights of the sessions were as follows:

1. Membership dues were set at $25 for the coming year and subscription to the AMA Journal was included in the dues.
2. It was suggested that state examining boards accept International Refugee Organizations' certification in lieu of other evidence of graduation and professional status for displaced physicians.
3. Approved the formation of a General Practice Section in hospitals, and approved the manual of the American Academy of General Practice for use by the general practice section in hospitals.
4. Recognized the need for, and approved the formation of, a medical student organization. Disapproved the present Association of Interns and Medical Students.
5. Distributed a report of an exhaustive study of medical education and medical plans in Great Britain which will be published in full in the AMA Journal in serial form beginning shortly.
6. Approved the expansion of the Washington office.
7. Disapproved the issuance of a separate Bulletin for the Women's Auxiliary.
8. Accepted the treasurer's and auditor's report.
9. Approved plans of the National Education Campaign.
10. Referred to the Board of Trustees reports on cost of medical care, and the survey of cults.
11. Decided status of Department of Racial Discrimination is one for several states to handle.
12. Discussed at great length the problems relating to Veterans' Medical Care and could come to no satisfactory conclusion, so voted to table the matter for further study and report at the Interim session.
13. Approved the inclusion of nursing services in prepayment plans.
14. Approved the report of the Commission on Chronic Illness.
15. Rejected the New Jersey plan for medical care because of too many controversial issues, but commended New Jersey and stated the plan had many sound principles.
16. Approved income tax exemption for post-graduate study.
17. Opposed reorganization Plan No. 27 as proposed to the U. S. Congress.
18. Opposed Medical Care plans now in Congress as well as federal aid to medical schools.
19. Authorized a study committee to augment the twelve-point plan of the American Medical Association.
20. Suggested enabling legislation for federal emergency medical service.
21. Stated that medical care for members of the United States armed forces was the government responsibility only, and this does not include their families. The report was referred to the Board of Trustees.
22. Set the Interim Session at Cleveland in December, 1950.

One of the most controversial issues before the convention was the report of the Committee on Hospitals and the Practice of Medicine. This committee, which is now called the Correlating Committee on Extension of Hospitals and Other Facilities of the Council on Medical Service, incorporated some of the previous Hess report on hospitals and practice of medicine. Some parts of the report were deleted and some changed. This report evoked so much discussion and so much parliamentary debate and argument that the House ordered it printed. Therefore, a detailed discussion on this section of House activities will be deferred until the official transcript of what actually took place is received.

continued on page 422



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HANGER ARTIFICIAL LIMBS
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REPORT OF AMA DELEGATE

concluded from page 420

Your delegate takes this opportunity to remind all members of the Society that the problems of medical care and the business of the state societies is assuming a larger importance in every passing month, and that one delegate to the National Convention for any state is totally insufficient. Without the able assistance and cooperation of the President and Vice-President of the state society, proper attention to your affairs could not be given because of overlapping schedules and the long meeting hours at these conventions. The state with one delegate is at a disadvantage, and the state's interest suffers as a result. It is to be hoped that legislation will be approved in the future whereby each state will have at least two delegates. Your sincere consideration of this problem is solicited.

CHARLES L. FARRELL, M.D.

AMERICAN DEMOCRACY ON TRIAL

concluded from page 414

Some day I hope an observer in this country will exclaim with equal admiration: "See how these doctors and these oil men love their democracy" — judging us by our actions, and not by our claims.

And when the day comes that this is said not of us alone, but of more Americans, on that day the future of American democracy will be assured.

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Since that time, clinical studies conducted by more than a thousand investigators have indicated a broad spectrum of usefulness for this hormonal substance.

As a result of steadily increasing production, adequate supplies of Cortone now are available for therapeutic use by the physician.

Among the conditions in which Cortone has produced striking clinical improvement are:

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CORTONE Acetate (Cortisone Acetate Merck) is available to all hospitals registered by the American Medical Association. For the present, this drug is to be used, during the initial period of treatment, only in hospitalized patients.

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(11-Dehydro-17-hydroxycorticosterone-21-Acetate)

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Manufacturing Chemists

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**Trade-mark of Merck & Co., Inc. for its brand of cortisone.*

THE CARE OF HAND INJURIES

The 4th in a series of articles prepared by the American Society for Surgery of the Hand, and distributed by the Committee on Trauma, American College of Surgeons

IV

LACERATED WOUNDS

I *Protection of the Hand* (Abstract of Article I)

The first-aid care of wounds of the hand is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. The best first-aid management consists in the application of a sterile protective dressing, a firm compression bandage and immobilization by splinting in the position of function*. No attempt should be made to examine, cleanse, or treat the wound until operating room facilities are available.

II *Requirements of Early Definitive Treatment* (Abstract of Article II)

Early definitive care requires thorough evaluation of the injury with respect to its cause, time of occurrence, status as regards infection, nature of first-aid treatment and appraisal of structural damage. For undertaking the definitive treatment the conditions required are a well-equipped operating room, good lighting, adequate instruments, sufficient assistance, complete anesthesia, and a bloodless field. Treatment itself consists of aseptic cleansing of the wound, removal of devitalized tissue and foreign material (exercising strict conservation of all viable tissue), complete hemostasis, and the repair of injured structures, to be followed by protective dressing to maintain the optimum position. After-treatment consists of protection, rest and elevation during healing, and early restoration of function by directed active motion.

III *Surface Injuries* (Previously circulated)

IV *Lacerated Wounds*

Lacerations may damage skin, fat, fascia, muscles, tendons, tendon sheaths, blood vessels, nerves and, more rarely, joint or bone. The treatment of such injuries has four objectives:

1. Protection from infection.
2. Restoration of structures.
3. Avoidance of deformity.
4. Early restoration of function.

These objectives are furthered by proper first-aid care, as outlined in I *(Protection of the Hand)* and by definite treatment.

A — Definite Treatment

To be undertaken only under the proper conditions and according to the principles outlined in II *(Requirements of Early Definitive Treatment)*. Careful history of the injury should be followed by examination of the hand to determine:

(1) Location and extent of the wound.
(2) Source of major bleeding.
(3) Presence of foreign material.
(4) Function of tendons, to be tested *against resistance.*
(5) Function of intrinsic muscles.
(6) Condition of nerves as regards both sensory and motor functions.
(7) Integrity of bone and joint.

Following anesthetization of the patient and application of hemostatic blood pressure cuff (not to be inflated above 300 mm), definitive treatment of the wound consists of:

(1) Thorough cleansing of wound region and then of entire hand and forearm with soap and water or bland detergent.
(2) Removal of foreign material from the wound.
(3) Careful, gentle, thorough, but conservative excision of devitalized tissues, sparing all structures that may survive.
(4) Repeated cleansing of wound by irrigation with warm normal saline solution.
(5) Securing and ligation of divided blood vessels.

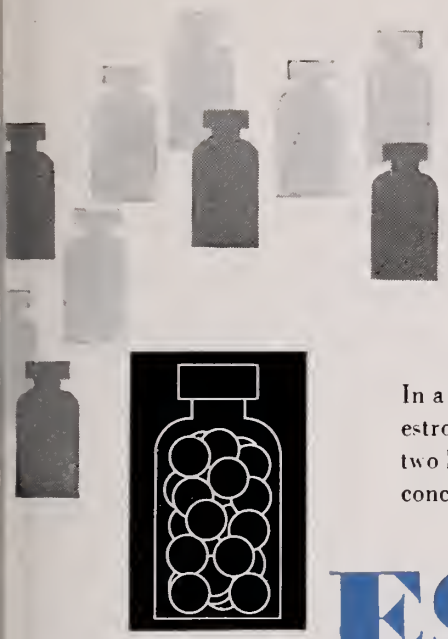
These general measures are followed in appropriate cases by repair of damaged structures. Proper wounds for this repair are:

(1) Those in which infection has not become established.
(2) Those not grossly contaminated by highly infective material.
(3) Relatively clean wounds not more than three or four hours old.

In general, wounds not fulfilling these criteria

continued on page 426

* Position of function or position of grasp: wrist hyperextended in cock-up position; fingers in mid-flexion and separated; thumb abducted and in mid-flexion, with tip pointing toward little finger.



10 *Estrogens were compared*

In a recent clinical comparison of ten estrogens administered by various routes to two hundred menopausal women, the conclusion was reached that:

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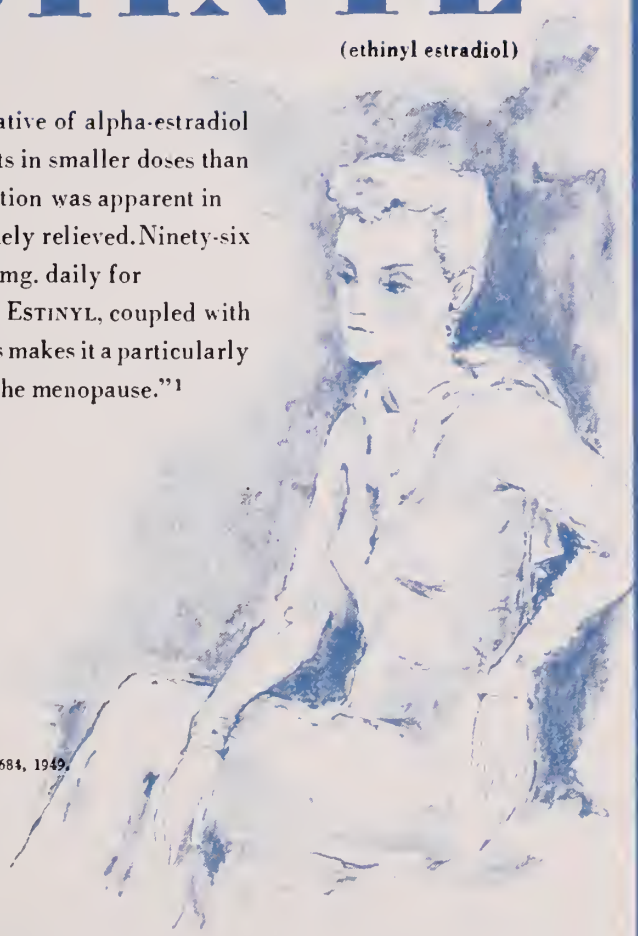
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1. Perloff, W. H.: Am. J. Obst. & Gynec. *58*:684, 1949.



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CARE OF HAND INJURIES

continued from page 424

are better left unrepaired to await secondary closure and later reconstructive surgery. They should, nevertheless, be as carefully cleansed of foreign matter and dead tissue as are those prepared for primary closure. In such cases severed nerve ends may be identified with nonabsorbable sutures or lightly united.

Repair of damaged structures:

(1) Nerves

a. All severed nerves should be repaired, including the digital nerves.

b. Fine arterial silk on fine needles should be used, accurately approximating the nerve ends by small interrupted sutures placed around the periphery. These sutures should include only the perineurium, not the nerve bundles. It is important to avoid axial rotation, particularly in nerves having both motor and sensory function.

c. Nerves are to be distinguished from tendons, especially at the wrist, by their anatomical position, softer texture, pinker color, small surface capillaries, and distinct nerve bundles seen on cut ends. Pulling on a nerve will not flex a finger.

d. Nerves should be handled gently, never crushed, rubbed, or allowed to become dry.

(2) Tendons

a. All severed tendons should be repaired, including the tendons of intrinsic muscles.

An important exception to this rule concerns flexor tendons severed within the flexor sheath or in the digital flexor canal. Primary suturing of the flexor profundus in this location rarely succeeds in restoring useful function even if the flexor sublimis is removed. Suturing both flexor sublimis and profundus in this area almost invariably results in failure. Should even minor infection occur, failure is assured. With rare exceptions, it is sound practice to repair the skin and digital nerves only, leaving the flexor tendons for secondary reconstruction when severed in this region.

b. Nonabsorbable sutures of silk or wire are used accurately to approximate the severed tendon ends after they have been cleanly squared off with a sharp knife.

c. Additional incisions to secure retracted tendon ends should follow flexion creases. They should be curved or transverse, never longitudinal, and never in the palmar or dorsal midline of a finger.

d. Tendons should be handled gently; never crushed, rubbed, or allowed to become dry.

(3) Muscle

a. Severed muscles should be lightly approximated with interrupted mattress sutures, avoiding tension and constriction.

b. Muscle thus repaired should be alive, contractile and vascular, all devitalized shreds being trimmed away.

Following these procedures, the hemostatic blood pressure cuff is released to permit identification, control and ligation of bleeding vessels. The field should be dry before closure of the wound.

(4) Fascia

Severed fascial and ligamentous tissue should be repaired with interrupted mattress sutures, avoiding tension.

(5) Subcutaneous tissue

Subcutaneous fatty tissue may be lightly approximated with interrupted fine sutures.

(6) Skin

The skin should be closed with fine, nonabsorbable sutures.

(7) Dressing

Firm pressure dressing is applied, the fingers being separated, with gauze between them. The hand is immobilized by splinting in the position of function, except when suture of severed tendons requires splinting in a position to insure the least strain on their suture lines. If nerves have been severed, the position of function is particularly important to prevent deformity due to contracture of active muscles when their opponents are denervated and paralyzed.

B — Aftercare

(1) Antibiotics and tetanus antitoxin (or toxoid) are administered systemically as prophylaxis against infection.

(2) The extremity is kept elevated for the first three or four days.

(3) Dressings are not removed for several days, usually one week, unless infection develops.

(4) The healing of severed tendons and nerves requires three weeks of uninterrupted immobilization.

(5) When nerves are severed, corrective splinting is necessary until reinnervation of paralyzed muscles has occurred.

(6) Restoration of function is best secured, after healing, by directed voluntary exercise and appropriate occupational therapy.

SURGEONS TO MEET IN BOSTON ON OCTOBER 23

Dr. Arthur W. Allen of Boston is Chairman of the Board of Regents and Dr. Frederick A. Coller of Ann Arbor is President of the American College of Surgeons. Dr. Thomas H. Lanman is Chairman of the Boston Committee on Arrangements for the 1950 Clinical Congress. At the Presidential Meeting on Monday evening, October 23, Dr. Henry W. Cave of New York will be installed as President, and Dr. Warren H. Cole of Chicago and Dr. G. Gavin Miller of Montreal as First and Second Vice Presidents respectively.

The American College of Surgeons was founded in 1913 by surgeons of the United States and Canada and now has a total fellowship of 15,500. Several hundred new Fellows will be admitted at the 1950 Convocation on the evening of October 27 during the Clinical Congress in Boston.

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OPERATION OF MEDICAL DIATHERMY EQUIPMENT

Regulations of the Federal Communications Commission

Many members of the Society have made inquiry relative to the operation of diathermy equipment in view of regulations adopted by the Federal Communications Commission.

Equipment manufactured prior to July 1, 1947, may be operated until June 30, 1952, without type approval or certification, provided such operation complies with the requirements of Section 18.51 (see below). After June 30, 1952, type approval or certification will be necessary for the continued use of such equipment.

Section 18.11 and 18.12, stated in full below, outline the provisions governing the operation of diathermy equipment designed to operate within the allocated bands and outside the allocated bands respectively. *Present equipment* may be operated after June 30, 1952, *provided* such operation complies with the provisions of either section 18.11 or 18.12.

Operation Without a License — Medical Diathermy Equipment

Sec. 18.11

OPERATION WITHIN ASSIGNED FREQUENCY BANDS.

A station license is not required for the operation of medical diathermy equipment within assigned frequency bands provided such operation meets the following conditions:

(a) Such operation must conform to the general conditions of operation set out in the guarantee or certificate required by (c) and (d) of this Section. Operation must be confined to one or more of the bands of frequencies hereafter set forth:

Assigned band	*Center frequency of channel*	*Tolerance from center frequency*
13,553.22-13,566.78 kc	13,560 kc	± 6.78 kc
26,960.00-27,280.00 kc	27,120 kc	±160.00 kc
40,660.00-40,700.00 kc	40,680 kc	± 20.00 kc

The operation of any medical diathermy equipment or device on frequencies other than those listed hereinabove shall be discontinued after the effective date of the Atlantic City Radio Regulations if interference be caused to any authorized services. However, in any event, operation of such devices on frequencies other than those listed above shall be discontinued after June 30, 1952, except as provided by Section 18.12.

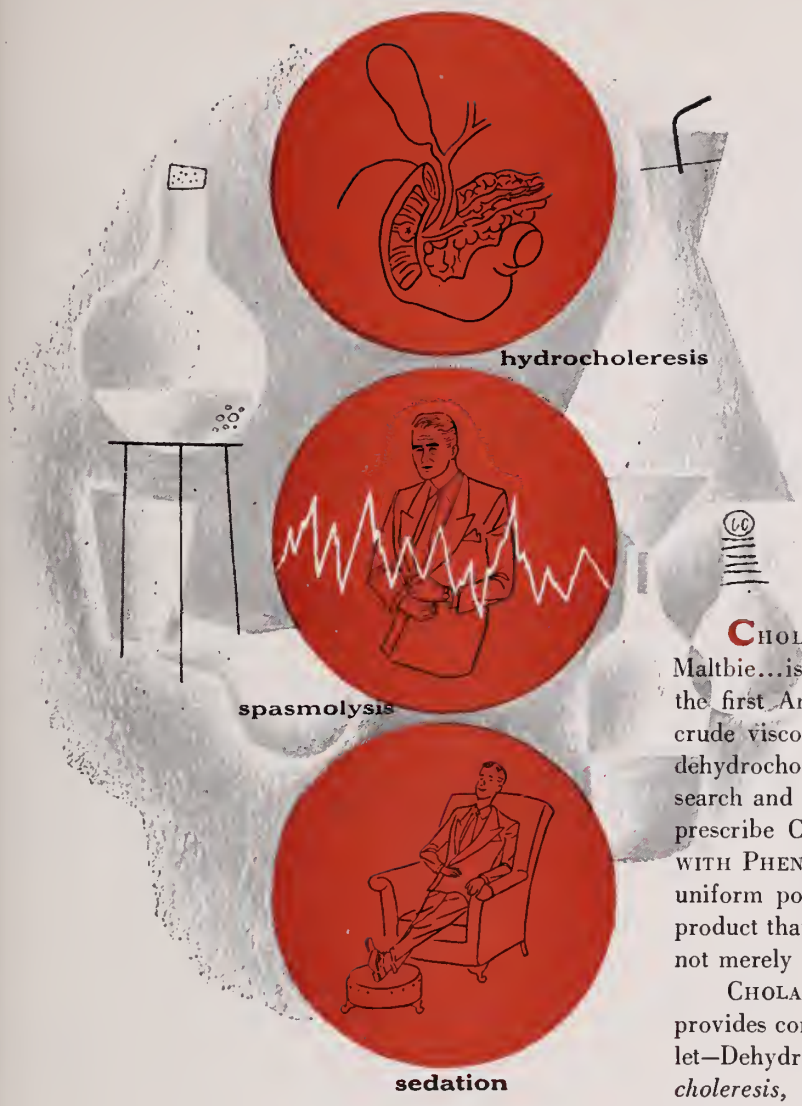
(b) Such operation may be without regard to the type or power of emissions being radiated. Spurious and harmonic radiations on frequencies other than those specified above shall be suppressed so that such radiations do not exceed a strength of 25 microvolts per meter at a distance of 1,000 feet or more from the medical diathermy equipment causing such radiations.

(c) With respect to equipment for which type approval has been received from the Commission in accordance with Sections 18.14-18.16 hereof there shall be affixed to each unit of equipment operated in accordance with (a) and (b) of this section, or posted in the room in which such operation occurs, a dated certificate of a competent engineer, or a dated certificate or name plate of the manufacturer of the equipment involved may reasonably be expected to meet the requirements of this section under the described conditions of operation for a period of at least three years. The certification required in this section shall describe with certainty the apparatus covered thereby.

(d) The owners or operators of equipment which has not received type approval but which is manufactured for operation without a license and designed to meet the technical requirements set forth under Paragraph 18.11 (a) and (b) shall have posted in the room in which such equipment is operated a dated certificate of a competent engineer, or a dated certificate or name plate of the manufacturer of the equipment, setting forth the general conditions under which such equipment should be operated and certifying that the equipment involved may reasonably be expected to meet the requirements of this section for a period of at least three years under the described conditions of operation. The certification required by this section shall describe with certainty the apparatus covered thereby, and shall include a brief statement of the engineering tests upon which such certification is based and the results thereof. Field intensity measurements in such tests shall be made in accordance with Section 18.13, below.

(e) No regular renewal of certification is required for equipment covered in (c) of this section. The certification required in (d) of this section shall be renewed at intervals of three years. Notwithstanding the above provisions with respect to renewal of certification, the certification required by (c) or (d) above shall be renewed for particular equipment by such date as the Commission

continued on page 430



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CHOLAN-HMB WITH PHENOBARBITAL provides comprehensive therapy in one tablet—Dehydrocholic Acid-Maltbie for *hydrocholeresis,* HMB (homatropine methylbromide) for *spasmolysis,* and phenobarbital for *sedation.*

CHOLAN-HMB WITH PHENOBARBITAL is indicated, in the absence of occlusive mechanical obstruction, in dyspepsia and constipation of biliary origin, biliary stasis, cholecystitis and cholangitis, biliary dyskinesia, and postoperative treatment.

Each CHOLAN-HMB WITH PHENOBARBITAL Tablet contains: Dehydrocholic Acid-Maltbie, 3¾ gr.; homatropine methylbromide, 1/24 gr.; phenobarbital, ⅛ gr.

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Cholan-DH/Tablets and Powder

Maltbie Laboratories, Inc., Newark 1, New Jersey

OPERATION OF MEDICAL DIATHERMY EQUIPMENT

concluded from page 428

may specify if the Commission has reason to believe that the operation of such equipment may be inconsistent with provisions of these rules or the source of interference to radio communication.

Sec. 18.12

OPERATION OUTSIDE OF ASSIGNED FREQUENCY BANDS

A station license is not required for the operation of medical diathermy equipment outside of the frequency bands specified in Section 18.11 (a) above provided such operation is in accordance with the general conditions of operation set out in the certification required in (c) below, and meets the following conditions:

(a) The equipment used in such operation shall be provided with a rectified and filtered plate power supply, power line filters, and shall be operated in a completely shielded room or space.

(b) The emission of radiofrequency energy generated by such operation, including spurious and harmonic emissions, shall not exceed a strength in excess of 15 microvolts per meter at a distance of 1000 feet or more from the medical diathermy equipment on frequencies other than those specified in Section 18.11 (a) above.

(c) There shall be affixed to each unit of equipment so operated, or posted in the room in which such operation occurs, a dated certification of a competent engineer, or a dated certificate or name plate of the manufacturer of the equipment setting forth the general conditions under which such equipment should be operated and certifying that under the described conditions of operation the requirements of this section may reasonably be expected to be met for a period of at least three years. The certification required by this section shall describe with certainty the equipment covered thereby, and shall include a brief statement of the engineering tests upon which the certification is based and the results thereof. Field intensity measurements in such tests shall be made in acordance with the provisions of Section 18.13, below.

(d) The certification required in (c) of this section shall be renewed every three years; *provided* that such certification shall be renewed for particular equipment by such earlier date as the Commission may specify if the Commission has reason to believe that the operation of such equipment may be inconsistent with the provisions of these rules or a source of interference to radio communication.

* * *

Sec. 18.51

EXISTING EQUIPMENT

The provisions of this Part shall not be applicable until June 30, 1952, to diathermy and industrial heating equipment, the manufacture and assembly of which was completed prior to July 1, 1947, nor shall they be applicable until April 30, 1953, to miscellaneous equipment, the manufacture and assembly of which was completed prior to April 30, 1948: Provided that the foregoing provisions of this section shall be applicable only if such steps as may be suitable under the circumstances are promptly taken to eliminate interference to authorized radio services resulting from the operation of equipment manufactured prior to the respective dates hereinabove set forth.

ANESTHETISTS ELECT

The Rhode Island Society of Anesthesiologists, most recent of the ASA component societies, having been chartered on June 12, elected new officers.

President ..... Priscilla Sellman, M.D.
Vice-President ..... Cecil Metcalf, M.D.
Treas. and Sec. ..... Edward Damarjian, M.D.

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Each capsule and enteric-coated tablet contains:

Theophylline Sadium Acetate .....(3 gr.) 0.2 Gms.
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Annual Reports of Committees, *1949-1950*

Report of Organization Committee

This year the Organization Committee set for its goal the policy of giving to every eligible doctor's wife in the State a personal invitation to join the Auxiliary.

At a luncheon meeting held at the Providence Plantations Club in December, the names of nearly 400 eligible potential members were divided among the committee according to medical districts. Since Providence had by far the largest number, a subcommittee was formed and the names were again divided to spread the work among a larger group. Likewise, in other districts, similar methods of personal contact were adopted.

The committee is pleased to report the number of doctors' wives who accepted, according to medical districts, as follows:

Kent	4
Newport	6
Pawtucket	11
Providence	70
Washington	11
	102
Total new members	102

It is with sincere thanks to the members of this committee and to all who assisted in bringing new members to the Auxiliary that this report is presented.

Respectively submitted,

Mrs. J. Murray Beardsley, *Chairman*
Mrs. Royal C. Hudson — *Kent*
Mrs. Richard Rice — *Newport*
Mrs. Edwin F. Lovering — *Pawtucket*
Mrs. Thomas Perry, Jr. — *Providence*
Mrs. Hartford P. Gongaware — *Washington*
Mrs. Harry Levine — *Woonsocket*

Report of Editorial Committee

Since the duty assigned to the Editorial Committee has been to take care of newspaper publicity for the meetings of the Auxiliary, it has not been necessary for us to hold committee meetings. The work of the committee has been materially lightened because of the publicity arranged by Mr. John E. Farrell, the able Executive Secretary of the Medical Society. Publicity for the Auxiliary meetings and a report of the fall meeting were given to the Providence Journal-Bulletin. Mrs. Henry J. Hanley took care of the publicity for the March meeting.

It has been a pleasure to me to have a share, although slight, in the activities of our Auxiliary.

Respectfully submitted,

Mrs. Peter Pineo Chase, *Chairman*
Mrs. Henry J. Hanley
Mrs. Louis I. Kramer

Report of Public Relations Committee

The Public Relations Committee had no regular meetings; however, it was represented by the Chairman at a meeting of the Rhode Island Medical Society's Public Relations Committee. At this time, a representative of the American Medical Association spoke in opposition to compulsory health insurance and stressed the part that women can play by: (1) acquiring effective endorsement against compulsory health insurance, by organizations of various types; and (2) the importance of participation in the Medical Society's Speakers Bureau.

The Rhode Island Medical Society, in conjunction with the Auxiliary, offered a course to train doctors and doctors' wives to do public speaking in this connection. The following members of the Auxiliary to the Rhode Island Medical Society have completed this course: Mrs. Edward Famiglietti, Mrs. Arthur Hardy, Mrs. Joseph C. Johnson, Mrs. Arnold Porter, and Mrs. Frederick Webster.

"Capitol Clinics," a commentary on current legislation and federal activities, will be sent, gratis, to any interested Auxiliary member, if she will write to the American Medical Association, 1523 L Street, N. W., Washington 5, D. C., and ask to be put on the mailing list.

Respectfully submitted,

Mrs. George E. Bowles, *Chairman*
Mrs. Jarvis D. Case
Mrs. Edmund T. Hackman
Mrs. Howard G. Laskey
Mrs. John M. Malone

continued on page 436





CALMS

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DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The annual golf tournament of the Pawtucket Medical Association was held June 22, 1950, at the Pawtucket Golf Club.

The meeting was called to order by President, Dr. James P. Healy at 8 p. m. It was voted that letters be sent, through the Rhode Island Medical Society, to our Senators and Representatives voicing opposition to compulsory health insurance, and protesting distribution of a brochure by the Democratic National Committee describing National Health Insurance.

The meeting adjourned at 8:30 p. m.

Dinner was served. Attendance 27.

Respectfully submitted,

HRAD ZOLMIAN, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held in the Nurses dining room of Memorial Hospital May 18, 1950. Twenty members were present.

The meeting was called to order by President Dr. James P. Healey at 7:30 p. m. The minutes of the April meeting were read by the secretary and accepted.

Among many communications there were the following:

1. A letter from the Army Surgeon-General's office concerning a cut in intern and residency training programs due to a decrease in need for specialists. It was announced that appointments are available, however.

2. A pamphlet from the Federal Security Agency on a policy of the American Association of Registration Executives and Council on Vital Records regarding the confidential nature of birth records.

3. Letters on the "Grass Roots" obligation of physicians in the stand against socialization which kind of action contributed toward the victory of Representative Smathers in Florida recently.

4. An announcement and questionnaire of the American Diabetes Association on plans for the Diabetes week to be held in November, 1950.

Dr. Mara urged that doctors get out and support candidates who are against socialization of medicine.

Dr. Kelly made a motion which was passed that a committee on Diabetes be appointed consisting of five members representative of the specialties.

Dr. Mara reported that the House of Delegates of the R. I. Medical Society went on record to keep the minimum for examination for insurance at $10 and that physicians accept lower fees under protest. Motion was made by Dr. Kelly and passed that the Pawtucket Medical Association approve of this stand and send communications to that effect to the House of Delegates and to members of the Pawtucket Medical Association.

Dr. Mara made a motion which was passed that a committee be formed to study and revise the fee schedule, and also, to list each member of the Pawtucket Medical Association according to the type of practice in which he is engaged. Results of this study will be reported when feasible. He introduced the Michigan fee schedule for suggestions as to minimum fees and methods. He stated the second part of the motion would rate a man as to specialty recognized by and protected by the local group.

A motion by Dr. Kelly was passed that a committee of three be appointed to study and arrange for the handling of emergency calls, and to confer with a similar committee from the Caduceus Club.

Dr. Henry Hanley reported from the Benevolent Committee of the Rhode Island Medical Society which is to build a fund from contributions by members to aid indigent or disabled members.

The meeting retired to the auditorium where Dr. Harry Hecker spoke on "Some Implications of the New Hormones." He discussed the history of ACTH and Cortisone, metabolic effects, and practice use in some diseases, and especially in Rheumatoid Arthritis and Rheumatic Fever.

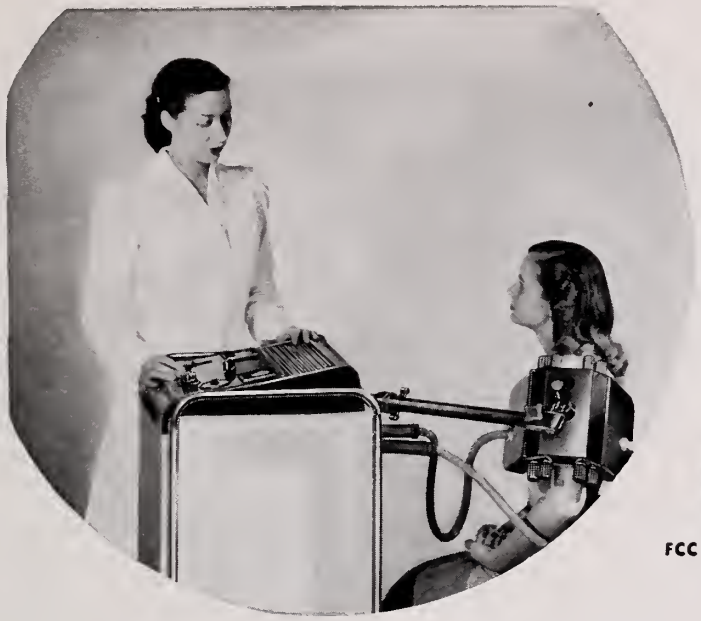
The meeting adjourned at 9:30 p. m.

Respectfully submitted,

HRAD ZOLMIAN, M.D., *Secretary*

KENNEY CLINIC — NOV. 1

Dr. M. A. Chapian, President of the Interns' Alumni Association of The Memorial Hospital, Pawtucket, Rhode Island, announces that The John F. Kenney Clinic Day will be held on Wednesday, November 1, 1950, and that the Guest Speakers for the Afternoon Session will be Dr. Frank H. Lahey and his associates. A detailed program will be published in the next issue of the JOURNAL.



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WOMAN'S AUXILIARY

concluded from page 432

I am grateful for the assistance given me by my committee and for that of Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society.

Respectfully submitted,
Mrs. William P. Davis, *Chairman*
Mrs. Henry B. Fletcher
Mrs. Manton C. Grimes
Mrs. Arthur Hardy
Mrs. William H. Tully, Jr.
Mrs. James P. O'Brien
Mrs. Harold Woodcome

Report of the Hospitality Committee

Our first meeting was held at the Rhode Island Medical Society Library on November 1, 1949. Doctors and their wives gathered after the meeting for a social hour. In keeping with the Halloween spirit we served doughnuts, cider, beer and cheese. If the chatter was any indication of a pleasant time, I feel sure they enjoyed it.

Our next meeting was a tea on March 14, 1950, at the Medical Society Library following a delightful talk by Dr. Dunlop. Tea and sandwiches were served with Mrs. Harris and Mrs. Farrell pouring. We were very happy to welcome so many old and new members at this meeting.

On May 10, 1950 we plan to have the Annual Luncheon Meeting to be held at the Agawam Hunt Club, Rumford, Rhode Island, and our earnest desire is to have a large group attend.

May I express my thanks and appreciation to the following ladies on my committee. They are:

Mrs. William N. Hughes
Mrs. Paul C. Cook
Mrs. Nathan Chaset
Mrs. Louis Cerritto
Mrs. Guy W. Wells
Mrs. George W. Waterman
Mrs. John G. Walsh
Mrs. Herman C. Pitts
Mrs. Joseph C. Johnston
Mrs. Walter S. Jones
Mrs. Herman A. Lawson
Mrs. Frank I. Matteo
Mrs. John F. Murphy
Mrs. Ralph D. Richardson
Mrs. Frederic W. Ripley
Mrs. George Young
Mrs. Craig Houston
Mrs. Henry McDuff
Mrs. Jarvis D. Case
Mrs. Henry J. Tweddell
Mrs. Ernest K. Landsteiner
Mrs. Stanley Davies
Mrs. Frank W. Dimmitt
Mrs. George E. Bowles

Respectfully submitted,
Mrs. Bertram H. Buxton, *Chairman*

Report of Legislative Committee

I am just as awed by the amount of medical, social and economic legislation under contemplation by our Government as I was a year ago when I first undertook to study the reports from the AMA Washington office. The AMA continues its campaign against socialized medicine; it not only opposes compulsory health insurance itself, but any bills that may establish precedences or aids for its inception. Among bills of this sort are the Corporate Health Act, National Health Act and National Health Insurance Act.

Republicans are demanding hearings on alternate health bills, as they argue the public should know what can be done to improve the nation's health services without the extremes advocated by the administration.

Although it passed the Senate last year, the School Health Bill is being delayed in the House and probably no action will be taken on it until Federal Aid to Medical Education and Local Public Health Units bills are disposed of. The AMA opposes one provision in the School bill — the authority to treat all children regardless of parents' ability to pay. The Local Units Bill, approved by the AMA for its local jurisdiction of health matters, will probably go through. Aid to Medical Education Bill is in executive Session of House Interstate and Foreign Commerce Committee.

There are 14 bills pending that supplement present authorized medical deductions and deductions of health expenses. AMA approves deductions for Voluntary Health Insurance.

The Social Security Amendments Bill, after weeks of hearings before the Senate Finance Committee, is in executive session in an attempt to arrive at an acceptable bill. The volume of testimony supported the opposition of AMA to total and permanent disability sections.

The Hospital Construction Program is in trouble

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in two ways: it will be set back if the economy action of the House Appropriations Committee is sustained, and it is found to be relatively ineffective in getting hospitals built in the areas where need is admittedly greatest.

President Truman has passed up a Cabinet-Rank Department of Welfare this year.

National Organizations (Crippled Children and Adults) as well as federal government agencies are sponsoring legislation for the Handicapped, as services for such are becoming so expensive, extensive and inclusive.

The nationwide effort to familiarize all physicians with the medical aspects of atomic warfare is in full swing through a "filtering down" principle. Meanwhile scholarships go begging at the Atomic Energy Commission, affecting cancer research and other medical fields involving the use of radioactive isotopes. There is objection to FBI investigation of scholarship holders.

U. S. Public Health Service is cooperating with the State of N. Y. in a *chronic disease* "pilot operation," seeking cures. PHS also shows grants to states for general health, TB, mental health, cancer and venereal disease totaled 47 million.

Respectfully submitted,

MRS. H. FREDERICK STEPHENS, *Chairman*
MRS. LEE G. SANNELA
MRS. RAYMOND H. TROTT
MRS. HOWARD UMSTEAD
MRS. EDWARD B. MEDOFF
MRS. GEORGE L. YOUNG
MRS. DONALD FLETCHER

Report of Program Committee

The Program Committee of the Women's Auxiliary to the Rhode Island Medical Society wishes to present its Fourth Annual Report. The year has been a successful one due to the desire, on the part of the members, to acquaint themselves with the various fields in which the Auxiliary can be of help to the Community in Medical Progress.

Since the State of Rhode Island has no County Auxiliaries, the programs are confined to three State Meetings, yearly.

The Calendar:

November 1, 1949—8:30 p. m. . . . Medical Library. Combined Meeting R. I. Medical Society and Woman's Auxiliary.
Speaker: Marjorie Shearon, Ph.D., Washington, D. C.
Subject: "National Legislation Affecting Medicine, the Outlook of 1950."

March 14, 1950—2:00 p. m. . . . Medical Library.
Speaker: Edwin Dunlop, M.D., Fuller Memorial Hospital, North Attleboro, Massachusetts, formerly of London, England.
Subject: "Why I left English Medical Practice."

May 10, 1950—12:15 p. m. . . . Annual Meeting and Luncheon. Agawam Hunt Club.
Speaker: Mr. Thomas A. Hendricks, Secretary, Council on Medical Service, American Medical Association.
Subject: "The Woman's Auxiliary in Community Leadership."



BOOK REVIEWS

A MANUAL OF CARDIOLOGY. By Thomas J. Dry, W. B. Saunders Company, Philadelphia, Pa., Second Edition, 1950. $5.00

Thomas J. Dry has revised the first edition of his "Manual of Cardiology" with a definite plan in mind. He has done well in presenting in a concise manner the most recent concepts of cardiovascular disease, and in discarding textbook material which is obsolescent because of inaccuracy or irrelevancy.

The book develops in an efficient manner the latest beliefs, with particular stress on congenital anomalies, coronary artery disease, including acute myocardial infarction, subacute bacterial endocarditis and congestive failure. The introduction is concerned with a practical and usually neglected subject: the approach to the patient with cardiac symptoms. From there the chapters in logical sequence deal with the normal heart and fundamental considerations of heart disease with particular reference to the concepts of cardiac reserve, predominant ventricular strain and its application to clinical cardiology. Specific features to be looked for in order to make a diagnosis of heart disease: cardiac murmurs, abnormal pulsations, alterations in size and contours and disturbances in rate, rhythm and conduction are logically developed and sufficiently emphasized.

Electrocardiography receives its proper attention stressing the Wilson unipolor precordial leads in positions 1, 3 and 5 in conjunction with limb leads. Wider exploration and the employment of special leads is resorted to whenever the indications arise in the individual case.

Throughout the book the author demonstrates the ability to sift out all but the important material and expresses himself in an impressive concise manner with sufficient stress on clinical approach. The bibliography is not exhaustive but contains the best references in the recent reviews. Scattered through the text are many helpful hints to therapy which are not always found in the usual texts.

The book is limited in scope as are all texts of its kind yet it is a valuable adjunct to the library.

ROBERT E. CARROLL, M.D.

AN ATLAS OF THE BLOOD AND BONE MARROW by R. Philip Custer. W. B. Saunders Company, Philadelphia, Pa., 1950. $15.00.

As stated by the author, the general aim of this monograph is to promote accuracy in diagnosis of diseases of the Hemolytopoietic System. The greatest contribution of this book is its adequate presentation of the pathology of the bone marrow, fulfilling a need that has long been present. The author, an authority in this field, draws freely on his rich personal experience. The photomicrographs are numerous and excellent.

The findings in the peripheral blood, the clinical and adjunct laboratory manifestations, are sufficiently presented to complete the disease picture in each instance. This reference combined with one such as Clinical Hematology, by Maxwell M. Wintrobe, supplement one another. They should be a part of the library of every doctor interested in diseases of the Hemolytopoietic System.

ROBERT J. WILLIAMS, M.D.
Pathologist

TEXTBOOK OF NEUROPATHOLOGY by Ben W. Lichtenstein, B.S., M.S., M.D. W. B. Saunders Co., Phil., 1949. $9.50.

The history of books pertaining to Neuropathology which have been published in these United States begins in the early nineteen thirties. An increasing number of such books under different authorship have appeared since that time period. Lichtenstein's "Textbook of Neuropathology" is another example. This phenomena does not, unfortunately, indicate an increased interest in Neuropathology in this country. It means, merely, that there is a market for these books since the advent of the system of Specialty Board Examinations which have prescribed the course of training to be followed to achieve certification.

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Study of Neuropathology often, then, becomes a means to an end, rather than an end in itself. This book suffers as a consequence of this conception.

One chapter is devoted to pathogenesis. Herein, the concept of causation as being due to a factor or a sum of factors is elaborated. The concept of causation as an inter-reaction of several factors does not prevail. On the basis of this latter concept, one attempts to arrive at pathogenesis through regarding pathology as a "reaction." This trend pervades thinking in general pathology. This disharmony with general pathology obliges the author to fall back on a morphological approach in organizing the material.

Three chapters headed "Degeneration" follow the chapter headed "Pathogenesis." The term "degeneration" carries from the past, the connotation of pathogenesis. Even though the word be given a morphological connotation solely, then the author is disregarding the existence of a reaction to injury, whatever that injury may be. This makes for confusion and this confusion is ironical, since the author indicates a preoccupation with nomenclature.

There is little attention to histopathology, which is so relevant in studying the reactions of the nervous system to injury. One glaring error under the classification of "histopathology" occurs on Page 11. A reaction of astrocytes to injury is pictured, rather than a normal protoplasmic astrocyte, as the designation indicates. On Page 265, similar cells are pictured and labelled as an example of protoplasmic astrocytoma. The references at the end of the chapters are useful and well done. A unique feature of the book, that of listing and describing neurological syndromes, is to be commended. For purposes of ready reference, this listing is ideal.

The publisher should be commended on the easy readability and pleasantness of the type. The illustrations are well produced.

HAROLD W. WILLIAMS, M.D.

THE MERCK MANUAL. 8th ed. Rahway, N. J., 1950. Regular Edition, $4.50; Thumb-Index, $5.00.

The Golden Anniversary Eighth Edition of the excellent Manual contains over 1500 pages of condensed, readily available medical information for the practicing physician. Revisions and additions were made to the material up until May 1, 1950, the day it went to press, so that the very latest developments in therapeutics could be included.

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MORNING SESSION

George W. Waterman, M.D., *Presiding*

10:30 a.m. CANCER OF THE LUNG
J. Gordon Scannell, M.D., Massachusetts General Hospital

11:00 a.m. APPROACH TO EXPERIMENTAL CANCER CHEMOTHERAPY
Joseph Leiter, PH.D., Bethesda, Maryland

11:30 a.m. RADIOACTIVE ISOTOPES IN CANCER DIAGNOSIS AND TREATMENT
Oliver Cope, M.D., Boston

12 noon CANCER OF THE STOMACH
Francis D. Moore, M.D., Boston

12:30 - 1:30 LUNCHEON IN BASEMENT DINING ROOM

1:30 p.m. BREAST CANCER—THE PROBLEM OF EARLY DIAGNOSIS
(Motion Picture)

* * *

AFTERNOON SESSION

Herman C. Pitts, M.D., *Presiding*

2:00 p.m. EARLY DIAGNOSIS AND TREATMENT OF BRAIN TUMORS
Arthur Elvidge, M.D., Montreal, Canada (Montreal Neurological Institute)

2:30 p.m. TUMORS IN CHILDREN
Harold W. Dargeon, M.D., New York City (Memorial Hospital)

3:00 p.m. CANCER OF ORAL CAVITY
Daniel Catlin, M.D., New York City (Memorial Hospital)

3:30 p.m. CANCER OF THE BREAST
Herbert W. Meyer, M.D., New York City (Bellevue Hospital)

4:00 p.m. ROUND TABLE DISCUSSION

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MIDWINTER MEETING

of the

Rhode Island Medical Society

at

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HEAR . . .

ERNEST K. LANDSTEINER, M.D. . . . Rhode Island Medical Society Delegate to the Rochester meeting on medical aspects of atomic warfare. . . .

JOSEPH W. HOWLAND, M.D. . . . Chief of the Division of Medical Services of the Rochester Atomic Energy Project.

ELMER HESS. M.D. . . . Erie, Pennsylvania, Physician whose report on Hospitals and Professional Relations has created widespread discussion in professional circles.

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Rhode Island Medical Society

See Page 476

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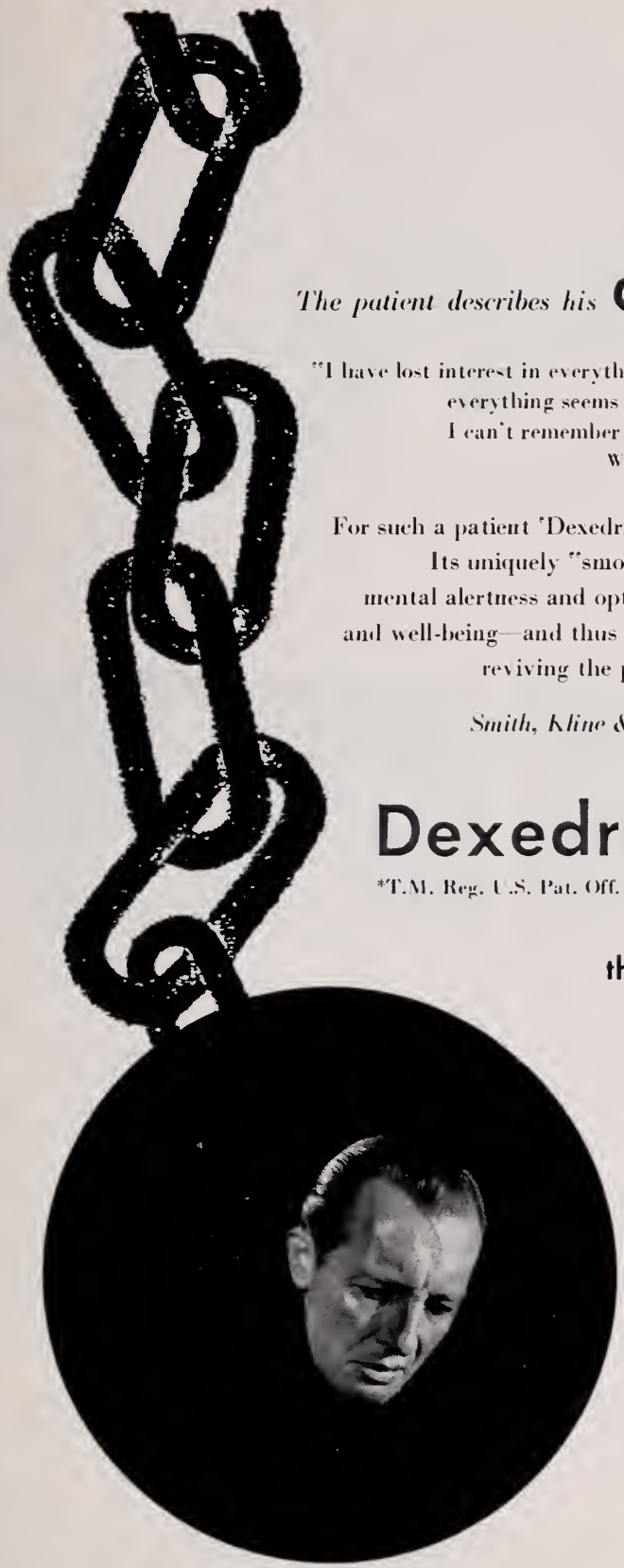
That a nutritious breakfast providing generous amounts of high quality protein prevents late morning hypoglycemia has been amply demonstrated. As shown by Thorn and co-workers,[1] and later confirmed by Orent-Keiles,[2] ". . . breakfast high in protein and low in fat and carbohydrate was followed by an improved sense of well-being and no symptoms of hypoglycemia."

Meat for breakfast—ham, sausage, bacon, breakfast steaks—is an appetizing means of increasing the protein content of the morning meal. Its biologically complete protein contains all essential amino acids, and serves well in complementing less complete proteins from other sources. Furthermore, muscle meat is an outstanding source of B complex vitamins and of iron.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

American Meat Institute
Main Office, Chicago... Members Throughout the United States



The patient describes his **depression:**

"I have lost interest in everything—I have no ambition any more—
everything seems futile—I feel frustrated and lonely—
I can't remember or concentrate—I am *all slowed up.*"
Washburne, A.C.: Ann. Int. Med *32*:265, 1950.

For such a patient 'Dexedrine' Sulfate is of unequalled value. Its uniquely "smooth" antidepressant effect restores mental alertness and optimism, induces a feeling of energy and well-being—and thus has the happy effect of once again reviving the patient's interest in life and living.

Smith, Kline & French Laboratories, Philadelphia

Dexedrine* Sulfate

*T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

the antidepressant of choice

tablets

elixir



NOW PROOF . . . in an instant, Doctor, PHILIP MORRIS are LESS IRRITATING

Just Make This Simple Test:





1 . . . light up a PHILIP MORRIS

Take a puff—DON'T INHALE. Just s-l-o-w-l-y let the smoke come through your nose. Easy, isn't it? AND NOW . . .

2 . . . light up your present brand

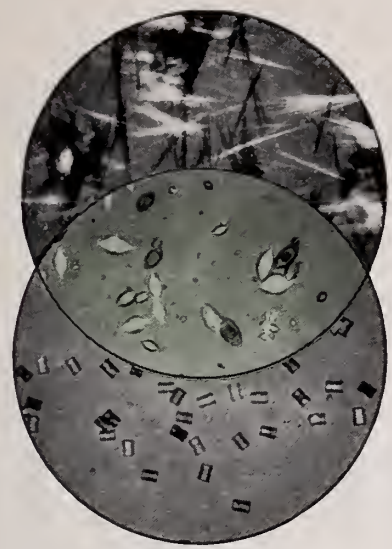
DON'T INHALE. Just take a puff and s-l-o-w-l-y let the smoke come through your nose. Notice that bite, that sting? Quite a difference from PHILIP MORRIS!

YES, your own *personal experience* confirms the results of the clinical and laboratory tests.* With proof so conclusive, would it not be good practice to suggest PHILIP MORRIS to your patients who smoke?

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100 Park Avenue, New York 17, N. Y.

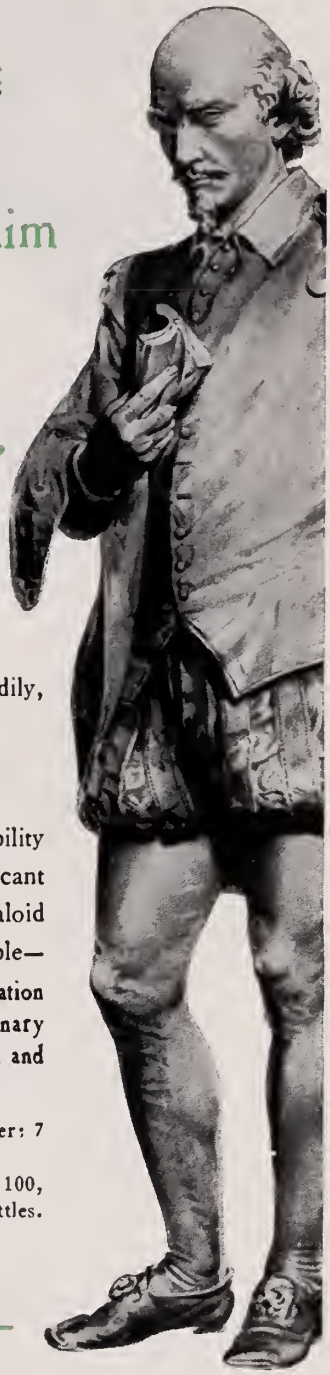
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592; Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



Photomicrographs showing calcium gluconate (upper circle) theobromine (bottom circle) and Calpurate crystals (center) resulting from Maltbie's synthesis.

"...It is twice bless'd;
"It blesseth him that gives and him that takes..."

—*Portia in*
The Merchant of Venice,
Act IV, Sc. 1.



Shakespeare, of course, is talking about the quality of mercy. But his famous lines remind us, not irreverently, of Calpurate, the *double salt* that affords the established benefits of xanthine therapy—without the plaguing side-effects of simple mechanical mixtures of theobromine and calcium gluconate.

Calpurate is the result of the synthesis in the Maltbie Research Laboratories of a *double salt* of calcium theobromine and calcium gluconate. Calpurate is indeed "twice bless'd."

It is absorbed slowly and steadily, which means—

. . . more sustained blood levels
. . . longer-lasting relief

Calpurate exhibits low solubility and does not liberate a significant amount of free theobromine alkaloid in the stomach, thus making possible—

... prolonged, uninterrupted administration in cardiac decompensation, coronary disease (angina pectoris, thrombosis), and hypertension.

Dosage: 1 or 2 tablets t. i. d.; Powder: 7 to 15 gr. t. i. d.

Available in drugstores in bottles of 100, 500, 1000 and as Powder in 1-oz. bottles.

for *trouble-free*, prolonged cardiac therapy prescribe the double salt—

Calpurate *Tablets and Powder*
Theobromine Calcium Gluconate Maltbie

Calpurate *with* Phenobarbital *Tablets*

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new broad-spectrum antibiotic
orally effective—well tolerated

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Active against specific organisms in the bacterial, rickettsial and protozoan groups

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Dosage: On the basis of findings obtained at over 100 leading medical research centers, 2 to 3 Gm. daily by mouth in divided doses q. 4 or 6 h. is suggested for acute infections.

Supplied: 250 mg. capsules, bottles of 16 and 100;
100 mg. capsules, bottles of 25;
50 mg. capsules, bottles of 25.

Pfizer

Antibiotic Division
CHAS. PFIZER & CO., INC., *Brooklyn 6, New York*

The RHODE ISLAND MEDICAL JOURNAL

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Editor-in-Chief: PETER PINEO CHASE, M.D.

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Volume XXXIII, No. 9 September, 1950

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Facts about a factor



The origin of Cottage Cheese is uncertain, but for many years now its popularity has been growing steadily. It's a delicious food and also an extremely valuable factor in a healthful, nourishing diet.

For instance, because of its bland flavor, soft consistency and low fat content, cottage cheese is often recommended for children. Cottage cheese is an important factor in various diets in which the protein content must be high and the fat content low. It is a good source of protein, phosphorus, riboflavin and calcium for all ages.



Hood's Creamed Cottage Cheese is delicious and versatile. It can be used in hors d'oeuvres . . . in place of a vegetable with the main course . . . in salads . . . and sandwiches. This versatility, along with its economy, high digestibility and excellent nutritive value, help make Hood's Creamed Cottage Cheese a valuable food for virtually every age.

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Dairy Products Since 1846

H P HOOD & SONS DAIRY PRODUCTS

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① Thesodate — Brewer IN ANGINA PECTORIS

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Thesodate has been proven effective in increasing the capacity for work in individuals suffering from coronary artery disease. One Thesodate tablet four times a day (after meals and at bedtime) helps to maintain improved heart action and increased coronary artery circulation.

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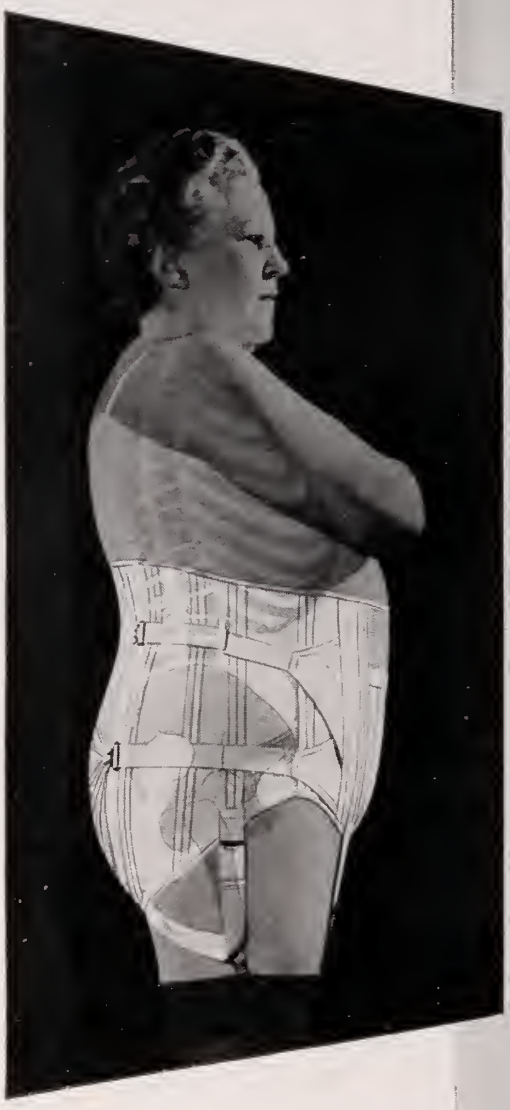
Amchlor cuts in half the number of tablets each patient takes when large amounts of ammonium chloride are prescribed. This convenience to the patient helps to insure full and complete use of the entire amount prescribed. Amchlor is useful in cardiac edema, hypertension, dysmenorrhea, Meniere's Syndrome, etc.

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WHEN OBESITY IS A PROBLEM



Clinicians have long noted that the forward bulk of the heavy abdomen with its fat-laden wall moves the center of gravity forward. As the patient tries to balance the load, the lumbar and cervical curves of the spine are increased, the head is carried forward and the shoulders become rounded. Often there is associated visceroptosis. Camp Supports have a long history among clinicians for their efficacy in supporting the pendulous abdomen. The highly specialized designs and the unique Camp system of controlled adjustment help steady the pelvis and hold the viscera upward and backward. There is no constriction of the abdomen, and effective support is given to the spine. Physicians may rely on the Camp-trained fitter for precise execution of all instructions.

If you do not have a copy of the Camp "Reference Book for Physicians and Surgeons", it will be sent on request.

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World's Largest Manufacturers of Scientific Supports
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Windsor, Ontario • London, England

Authorized Service
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THIS EMBLEM is displayed only by reliable merchants in your community. Camp Scientific Supports are never sold by door-to-door canvassers. Prices are based on intrinsic value. Regular technical and ethical training of Camp fitters insures precise and conscientious attention to your recommendations.



"Premarin"—a naturally occurring conjugated estrogen which has long been a choice of physicians treating the climacteric—is earning further clinical acclaim in the treatment of functional uterine bleeding.

The aim of estrogenic therapy in functional uterine bleeding is to bring about cessation of bleeding, and to produce subsequent regulation of the cycle. Once hemostasis is achieved, the maximum daily dosage of "Premarin" must be continued to prevent recurrence of bleeding. This schedule forms part of cyclic estrogen-progesterone treatment for attempted salvage of ovarian function.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water-soluble conjugates.



An "estrogen of choice for hemostasis is 'Premarin' in tablets of 1.25 mg. ... The usual dose for hemostasis is 2 tablets three times a day. If bleeding has not decreased definitely by the third day of treatment the dosage level may be increased by 50 per cent."*

*Fry, C. O.: J. Am. M. Women's A. 4:51 (Feb.) 1949

"PREMARIN"®

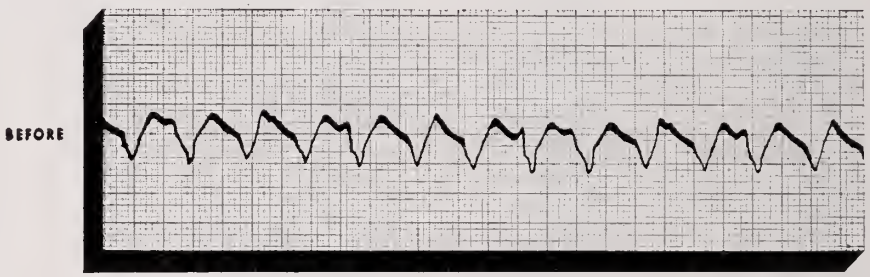
Estrogenic Substances (water-soluble)
also known as Conjugated Estrogens (equine)

Four potencies of "Premarin" permit flexibility of dosage: 2.5 mg., 1.25 mg., 0.625 mg., and 0.3 mg. tablets; also in liquid form, 0.625 mg. in each 4 cc. (1 teaspoonful).

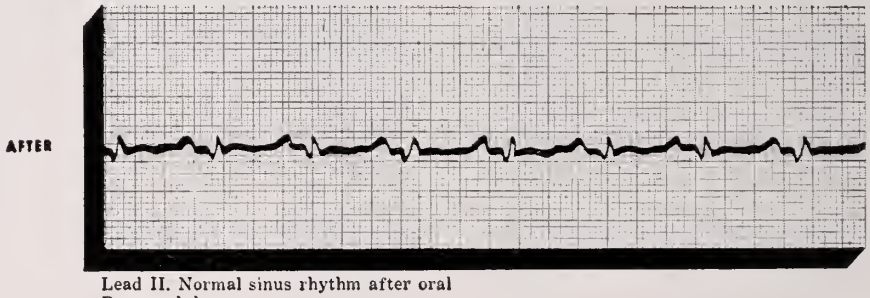
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22 East 40th Street, New York 16, N. Y.

5009

A New Drug..for the treatment of ventricular arrhythmias



Lead II. Ventricular tachycardia persisting after six days of oral quinidine therapy (8 Gm. per day).



Lead II. Normal sinus rhythm after oral Pronestyl therapy.

Effective in some patients with ventricular tachycardia who failed to respond to quinidine

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride

SQUIBB

"PRONESTYL" IS A TRADEMARK OF E. R. SQUIBB & SONS

new product brief

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride

for the treatment of ventricular arrhythmias

What is it?

Pronestyl Hydrochloride is Squibb procaine amide hydrochloride. Structurally, Pronestyl differs from procaine only by the presence of the amide grouping (.CO.NH.) in Pronestyl where procaine has the ester grouping (.CO.O.)

How does it act?

The action of Pronestyl is probably due to a direct depressant action on the ventricular muscle. In auricular arrhythmias, preliminary observations indicate that Pronestyl slows auricular rate but usually does not re-establish normal sinus rhythm. At present, Pronestyl is not recommended in the treatment of auricular arrhythmias.

When is it indicated?

In conscious patients, for the treatment of ventricular arrhythmias.

During anesthesia, to correct cardiac arrhythmias.

What are its advantages in ventricular arrhythmias?

As compared with quinidine: Unlike quinidine, no important toxic symptoms have been reported following the use of Pronestyl orally. In therapeutic dosage, Pronestyl orally does not produce the nausea, vomiting, and diarrhea often caused by quinidine. At high oral dosage, these symptoms may appear

Whereas intravenous administration of quinidine is hazardous and unpredictable, Pronestyl may be given intravenously with relative safety.

Pronestyl has been found effective in some patients who failed to respond to quinidine.

As compared with procaine: For arrhythmias, procaine is used only in anesthetized patients because its dose in unanesthetized patients is too toxic for clinical use. Pronestyl can be used in conscious and anesthetized patients.

Intravenously, Pronestyl is much less toxic than procaine. In the recommended intravenous dosage, Pronestyl does not cause the central nervous system stimulation typical of procaine in conscious patients.

Procaine is unstable, being rapidly hydrolyzed in the plasma to para-aminobenzoic acid and diethylaminoethanol. Pronestyl is not affected by the plasma procaine esterase, consequently it is much longer acting than procaine.

Procaine is not used orally because of its instability in the organism; Pronestyl can be used orally and intravenously.

What are its side effects?

Oral administration of Pronestyl in doses of 3-6 grams per day, for periods of time varying from 2 days to 3 months, produced no toxic effects as evidenced by studies of the blood count, urine, liver function, blood pressure, and electrocardiogram. Intravenous administration to patients without ventricular tachycardia produced only a moderate and transient hypotensive effect in about one-third of the subjects. However, during intravenous administration to patients with ventricular tachycardia, a striking hypotensive effect was almost invariably present. This disappeared concurrently with the establishment of a normal rhythm. Further studies are in progress to see whether the drug may be given intravenously over a period of time longer than five minutes so as to revert the ventricular tachycardia without causing hypotension. That this may be possible is indicated by the fact that some episodes of ventricular tachycardia have been successfully treated by oral administration without significant change in blood pressure. Electrocardiographic changes: prolongation of QRS and QT intervals and occasional diminution in voltage of QRS and T waves have occurred.

What is the dosage?

IN CONSCIOUS PATIENTS

For the treatment of ventricular tachycardia.

ORALLY: 1 Gm. followed by 0.5-1.0 Gm. every four to six hours as indicated.

INTRAVENOUSLY: 200-1000 mg. (2 to 10 cc. Pronestyl Hydrochloride Solution). *Caution—administer no more than 200 mg. (2 cc.) per minute.*

Hypotension may occur during intravenous use in conscious patients. As a precautionary measure, administer at a rate no greater than 200 mg. (2 cc.) per minute to a total of no more than 1 Gm. Electrocardiographic tracings should be made during injection so that injection may be discontinued when tachycardia is interrupted. Blood pressure recordings should be made frequently during injection. If marked hypotension occurs, rate of injection should be slowed or stopped.

For the treatment of runs of ventricular extrasystoles.

ORALLY: 0.5 Gm. (2 capsules) every four to six hours as indicated.

IN ANESTHESIA

During anesthesia, to correct ventricular arrhythmias.

INTRAVENOUSLY: 100-500 mg. (1 to 5 cc. Pronestyl Hydrochloride Solution). *Caution – administer no more than 200 mg. (2 cc.) per minute.*

How is it supplied?

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.

Pronestyl Hydrochloride Solution, 100 mg. per cc., in 10 cc. vials.

SQUIBB

not "food allergy"... but "casein allergy"

Inability to tolerate milk casein is one of the most frequent causes of allergy in infants. Casein allergy, as manifested by such symptoms as gastrointestinal upsets and atopic eczema, may follow the ingestion of any animal milk. In true casein allergy, all animal milks, including goat's milk, must be avoided.

In such cases Mull-Soy provides the answer. Mull-Soy compares closely with cow's milk in nutritional values of protein, fat, carbohydrate, and minerals.

Mull-Soy is a liquid, pleasant-tasting, homogenized, stable (vacuum packed) food, high in unsaturated fatty acids.
At drugstores in 15½ fluidounce tins

For hypoallergenic diets in infants and adults look to

MULL-SOY®

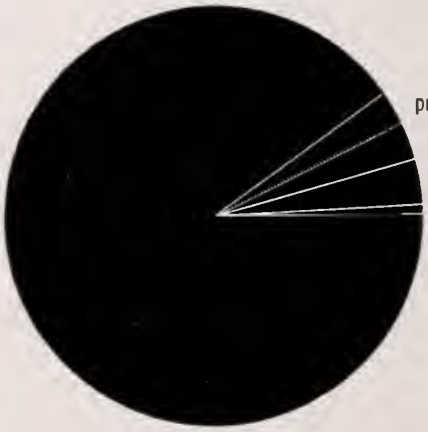
The Borden Company
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Mull-Soy diluted with equal volume of water

20 calories per fl. oz.

Average whole cow's milk



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THE CLINICAL RESPONSE In RHEUMATOID ARTHRITIS And Its VARIANTS

Among the conditions in which Cortone has produced striking clinical improvement are:

RHEUMATOID ARTHRITIS and Related Rheumatic Diseases

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EYE DISEASES, Including Nonspecific Iritis, Iridocyclitis, Uveitis, and Sympathetic Ophthalmia

SKIN DISORDERS, Notably Pemphigus, Angioneurotic Edema, Atopic Dermatitis, and Exfoliative Dermatitis, Including Cases Secondary to Drug Reactions.

CORTONE is available for use in hospitals having facilities for required laboratory studies, and also for use in nonhospitalized cases following initial therapy in such hospitals. These hospitals can supply physicians' requirements for Cortone.

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

**Trade-mark of Merck & Co., Inc. for its brand of cortisone.*

THE usual pattern of response to CORTONE begins with diminution in subjective stiffness, commonly within 24 to 48 hours, but sometimes within 6 hours after the initial dose. In many cases this symptom is significantly or completely relieved within a few days. Next, articular tenderness and pain on motion decrease. Finally, swellings of the joints diminish, sometimes fairly rapidly and completely, but occasionally more slowly and incompletely.

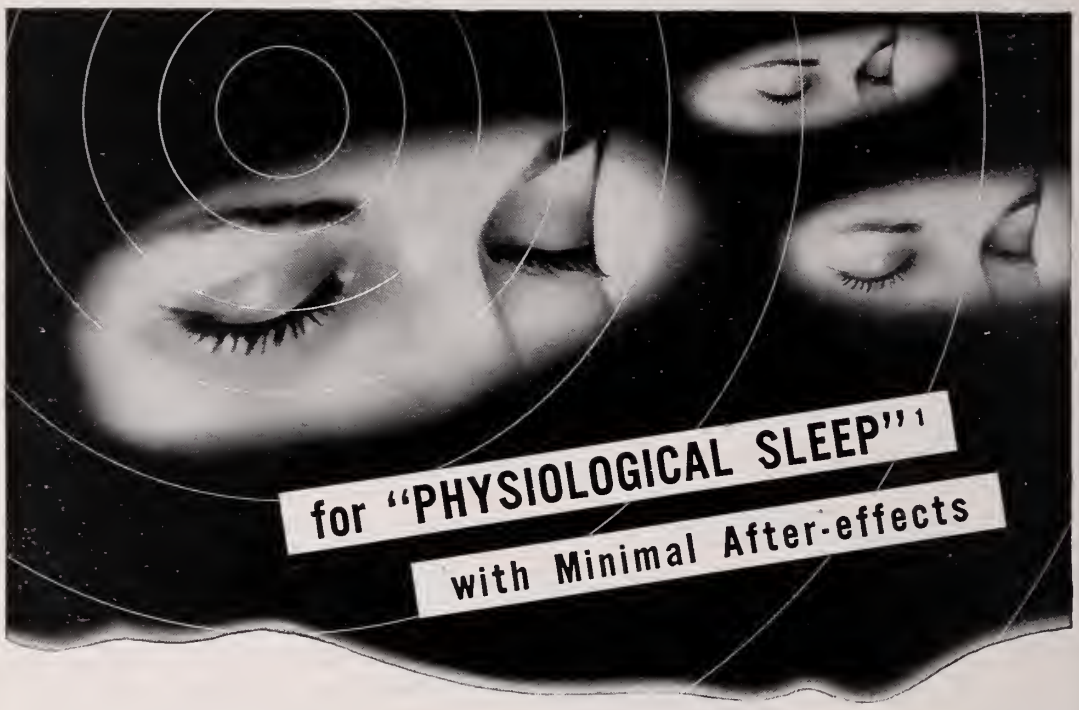
In many patients, mild soft-tissue deformities of the knees or elbows have disappeared within 7 to 10 days. An increase in muscle strength has been reported. The extent of return to normal has been limited, as must be expected, by the degree of permanent pathologic change present.

Appetite usually improves rapidly, and many patients have described a loss of the feeling of malaise associated with the disease and have experienced a sense of well-being, occasionally within several hours after initial administration of the drug.

When treatment with CORTONE is discontinued, signs and symptoms may begin to reappear within 24 to 48 hours, becoming gradually worse during the following 2 to 4 weeks. The degree of relapse varies, and is apparently unrelated to the duration of treatment. In some patients, however, the greater part of the remission has persisted for as long as several weeks or months. If CORTONE is re-administered when manifestations of the disease return, prompt remission is again induced.

Cortone
TRADE-MARK

ACETATE
(CORTISONE Acetate Merck**)**
(11-Dehydro-17-hydroxycorticosterone-21-Acetate)



Chloral hydrate, used in medicine since 1869, is, even today, "the standard hypnotic of its class."[1]

Goodman and Gilman observe that it "is unfortunately neglected today," and that the present widespread use of the barbiturates has ". . . caused the physician to lose sight of the fact that chloral hydrate is still one of the cheapest and most effective hypnotics."[2]

In FELLO-SED, supplementation with calcium bromide and atropine sulfate largely overcomes unwanted side-actions, enhances the sedative effect and provides valuable antispasmodic activity. It is presented in palatable liquid form.

[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

Available in 8 fluidounce bottles.

Adult Dose: As a sedative: ½ to 1 teaspoonful with water, every 3 or 4 hours or as directed. As a hypnotic, 1 to 2 teaspoonfuls or more with water at bedtime, or as directed.

FELLO-SED

FORMULA: Each fluidram (4 cc.) contains, in a palatable aromatic vehicle: Chloral Hydrate, 0.5 Gm. (7½ gr.); Calcium Bromide, 0.5 Gm. (7½ gr.); Atropine Sulfate, (1/480 gr.).



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how to avert an obstetrical emergency

There is a measure which prevents
nearly all hemorrhages
associated with childbirth.
Although most deliveries are normal,
a drug which can avert
an unpredictable emergency
is a wise investment in every case.
Consistent prevention
of mishap due to hemorrhage
is assured with the regular use
of 'Ergotrate Maleate'
(Ergonovine Maleate, U.S.P., Lilly).

Lilly



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on 'ERGOTRATE MALEATE' PRODUCTS
are supplied through your M.S.R.*

*M.S.R.—Lilly Medical SERVICE Representative



A 19" x 12" reproduction of this illustration by Joseph Feher is available upon request.

harvest for maternity

In the sun-drenched fields of southwestern Europe, workers gather a fungus growth called ergot. Although derived from a grain disease, it supports maternal health.

Unlike venerable crude extracts of ergot, which are erratic in effect, ergonovine is a pure substance that is uniformly potent. Introduced by the Lilly Laboratories as 'Ergotrate Maleate' (Ergonovine Maleate, U.S.P., Lilly), this reliable oxytocic lessens the complications of childbirth.

Lilly

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INDIANAPOLIS 6

INDIANA, U.S.A.

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXIII SEPTEMBER, 1950 NO. 9

ASTHMA IN INFANCY

WILLIAM P. BUFFUM, M.D.

The Author. *William P. Buffum, M.D., of Providence. Physician-in-Chief, Department of Pediatrics, Rhode Island Hospital.*

THIS is an analysis of the records of 49 infants with asthma seen before the age of two.

These patients are unselected cases seen in private practice. Three cases were left out because of insufficient data; otherwise this represents the total number of records that I have of asthma, seen before two years of age.

Heredity

Sixteen patients had only paternal ancestors or relatives with asthma or hay fever.

Thirteen patients had such allergic inheritance on the maternal side only.

Ten had such allergy on both sides.

Ten had no known allergic inheritance.

Types of Asthma

Eight patients had attacks of asthma with good health between attacks. This group all did well promptly.

Eighteen had persistent wheezing, present for months without cessation. In this group were all the severe and intractable cases.

Twenty-two patients wheezed frequently, with or without definite attacks. Some of these patients were troublesome but all did well, some quickly and some slowly.

Severity

Of the infants with asthma, six were severe cases with underdevelopment, malnutrition and barrel chest, and one of these died.

From this it seems probable that asthma beginning before the age of two has a tendency to be more severe than that beginning later.

To get more evidence on this point we picked out 22 children of all ages with especially severe asthma. In these cases the average age on onset of the asthma was two years and one month. One hundred consecutive cases of asthma in childhood showed an average age of onset of three years and four months. This supports the thesis that the earlier the asthma begins, the more severe it is likely to be.

Scratch Tests on Patients Coming During the First Year and During the Second Year

22 Patients under 1 Year		*27 Patients Age 1-2*	
Egg	6	Egg	11
Alternaria	6	Potato	7
Aspergillus	5	Feather	6
Hormodendron	5	Aspergillus	6
Penicillium	4	Dust	5
Potato	4	Beef	4
Beef	3	Spinach	4
Chicken	3	Salmon	4
Pork	3	Dog	3
Spinach	3	Kapok	3
Orange	3	Grass	3
Salmon	3	Alternaria	3
Milk	1	Horm.	3
Dust	1	Chicken	3
Etc.		Lamb	3
		Corn	3
		Peanut	3
		Mustard	3
		Milk	1
		Etc.	

Interesting Suggestions:

There were few positive house dust tests, especially in the group under 1 year.

There were many positive mold tests, especially under one year.

There were few positive milk tests, in spite of the fact that milk is the most important food factor.

Foods	*Clinical Sensitivities to Foods, which were Demonstrated, Listed in order of their Frequency*	*Clinical Sensitivities to Foods which were accompanied by Positive Scratch Tests*
Egg	15	10
Orange	12	5
Milk	10	3
Wheat	8	5
Spinach	6	4
Fish	5	4
Lamb	4	2
Potato	4	2
Beef	3	2
Peas	3	2
Tomato	3	0
Oats	3	1
Etc.	Etc.	Etc.

continued on next page

* Presented as an exhibit at the Eastern Area meeting of the American Academy of Pediatrics, at Philadelphia, Pa., March 30-April 1, 1950.

The positive scratch tests and the clinical sentitivities were demonstrated during the course of treatment, and not necessarily before two years of age.

Foods	*Positive Scratch Tests to Foods Listed in order of Frequency*	*Positive Scratch Tests to Foods which were accompanied by Demonstrated Clinical Sensivitity*
Egg	18	10
Potato	11	2
Beef	10	2
Spinach	9	4
Wheat	7	5
Chicken	7	0
Fish	7	4
Orange	7	5
Corn	7	0
Pork	6	1
Peanuts	6	0
Lamb	5	2
Etc.	Etc.	Etc.
Milk	3	3

The striking point in these tables is that milk is a common cause of clinical sensitivity and an uncommon cause of positive scratch tests.

A Very Satisfactory One

J. B. 8 months of age

C. C. Snuffling and difficulty in breathing since 3 weeks of age.

F. H. Maternal aunt had eczema.

P. I. At first had mostly snuffling and rattling in throat with occasional dyspnea. For last 2 months frequently uncomfortable with dyspnea and much mucous discharge from nose and throat. Was diagnosed "Thymus" and given X-ray treatments.

P. E. Condition good. Nose, throat and lungs negative.

Positive Scratch Tests:

8 months

Cat	+	Egg	+
Dust	+	Spinach	+
Wheat	+	Potato	+

Clinical Sensitivities Demonstrated:

dust, wheat, egg, spinach, potato, fish, beets, orange.

Treatment:

Avoidance of house dust and the foods that upset him. Injections of house dust.

Result:

For 5 years had occasional wheezing with colds or with mistakes in diet. Now 9½ years has had no wheezing or respiratory difficulty for 4 years.

The Most Unsatisfactory One

C. F. 1½ years old.

C. C. Wheezing spells for 2 months.

F. H. Mother; hay fever. 2 paternal uncles; asthma.

P. H. Had eczema and still has it.

P. I. Two months ago had pneumonia and since has had 3 wheezy spells lasting several days each. Coughs all the time.

P. E. Condition, fair, coarse rales throughout lungs.

Positive Scratch Tests:

	1½ yrs.	2 yrs.	4 yrs.	8 yrs.
Cat	++		++++	+++
Dog	+++		++	+
Horse	0		++	+
Feathers	0		+	0
Dust	+		+	0
Timothy	0		++	+−
Egg	+++	+	++	+
Aspergillus	+		0	0
Beef	+++	++++	+	0
Chicken	0	0	++	+−
Lamb	+	0	0	+
Potato	+	+	+	+
Corn	++	+	+++	0
Peanut	0	0	+	+
Mustard			++++	+++
Birch			0	++
Camel			++	0
Cow			++	+

Clinical Sensitivities Demonstrated.

Dog, wheat, milk, egg, peas, spinach, orange, tomato, grapes, peach, apples, oats.

She has been wheezing continuously except that twice she was relieved for 4 months following a course of Penicillin. She has just started taking Penicillin again, a 3 day course and then 50,000 units twice daily p. o.

The One with the Longest Follow-Up

J. M. 1, 11/12 years

C. C. Asthma for 1 month.

F. H. Mother; asthma.

P. H. Eczema at 3 months.

P. I. Started wheezing a month ago and has wheezed continuously since. (Later it was worse in the summer, but was continuous all the year round.)

Positive Scratch Tests:

	2 yrs.	4 yrs.	7 yrs.	8 yrs.	11 yrs.	14 yrs.	23
Timothy	0	0	0	0	0	++	+
Ragweed	0	0	+	++	+	+	0
Dog	++	0	++	++	++	+	0
Cat		0	++	+	++		0
Rabbit			0	0	0	+	0
Feather			0	0	0	+	0
Dust				++	++	+++	+
Egg		++	++	++++	+	+++	0
Orris		+	0	+	0	0	
Own Pillow (Kapok)						+	
Spinach	++++						
Potato	++						
Peas	++						

Clinical Sensitivities Demonstrated:

dust, ragweed, grass, dog, egg, spinach.

Result:

During the last year he was a little wheezy once, after contact with a dog.

One with Severe Vomiting

S. F. Age 1, 7/12

C. C. Wheezing attacks with dyspnea and cyanosis, and sometimes severe vomiting, occurring every week or two for 6 months.

F. H. Mother; asthma.

P. H. Much vomiting.

P. I. Wheezing attacks as described above with complete clearing between attacks.

P. E. Negative.

Scratch tests all negative.

Clinical sensitivities were not demonstrated but she seems much better on Mulsoy.

Treatment:

Avoidance of house dust, injections of house dust, molds and vaccine, and diet without milk.

Results:

Very little wheezing since starting treatment 2 years ago, none whatever for three months.

The Most Severe One

A. T. 22 months old

C. C. Asthma since 4 months of age.
F. H. Father; asthma. Mother; much bronchitis.
P. H. Eczema, still persists.
P. I. Asthma most of the time, worse in summer.
P. E. General condition fair. Slightly barrel chested. Lungs usually wheezy.

Positive Scratch Tests:

	22 months	4 yrs.	7 yrs.	9 yrs.
Horse	++++	++++	+	++++
Goat		+++	0	
Sheep		+	+	
Camel		++	+	
Cow		++++	++++	
Feathers	++++	++	0	0
Kapok	0	++	+	0
Dust	0	++	++	0
Timothy	0	+++	+	+
Ragweed	0	+	+	++
Alternaria	0	+−	+	+−
Aspergillus	0	0	+	+−
Hormodendron	0	+−	+	0
Wheat	0	++	+−	−
Milk	++	++	0	0
Egg	++++	+++	++++	+
Beef	+++	++	+	
Chicken	+	0	0	
Lamb	++	++	++	
Potato	+	+++	++	
Salmon	+	+++	++	
Corn	0	++	0	
Peanut	+++	+++	++++	
Pork	+++	+++	0	
Mustard	++++	+++	++	
Silk		++	0	
Fish Glue		++	+−	
Pyrethrum		++		
Tobacco		+++		

Clinical Sensitivities Demonstrated:

milk, egg, wheat, beef, lamb, pork, fish.

Treatment has been mainly by avoidance and injection all this time.

Result:

He still wheezes a good deal of the time, but appears normal, is a happy boy, and goes to school regularly.

The One Who Died

C. G. 22 months of age

C. C. Wheezing 4 months.
F. H. No allergy known.
P. H. Negative.
P. I. Has been steadily wheezy for 4 months with periods of moderate dyspnea.
P. E. Condition good. Lungs slightly wheezy.
Scratch tests were all negative.

No clinical sensitivities were demonstrated. Left town after 3 visits.

She was studied elsewhere and although she cleared in the hospital several times no continued improvement was made. She died at the age of 7 "All worn out from asthma" but no details are known.

Treatment

Inhalant allergens which are considered important in the individual case, and house dust and its producers and collectors are eliminated as far as possible.

Injections are given with extracts of all the inhalants which are thought to be of clinical importance. The dilution used at the start is not stronger than the weakest which will give a positive intracutaneous test. The intervals are usually 1 week for 4 injections and then are lengthened to 2, 3 or 4 weeks.

Some patients are treated with courses of Penicillin or Aureomycin. A few patients have been given Sulfadiazine for a period of months with good results. Pencillin and Aureomycin are now being tried on a few patients in daily doses for long periods.

Foods which by scratch skin test give large wheals with pseudopods and foods which are known to cause clinical allergic reactions are kept out of the diet. Other food allergies are sought for by provocative diet tests, in which the babies are put on a restricted diet, and then other foods are added one at a time, at intervals of 4 days. Particular pains are taken to test carefully for milk sensitivity.

Results of Treatment and Time According to Last Available Reports

	No Symptoms for 1 year or more	*Very slight wheezing once or twice during last year*	*Improved*	*Not Improved*	*Dead*	*No Report*
49 Patients	13	23	7	1	1	4
Results by Per cent	27%	47%	14%	2%	2%	8%
20 Patients followed more than 4 yrs.	4	10	4	1	1	

Conclusions

Asthma in infancy is common.

Asthma occurring in infancy tends to become severe and should be treated promptly and persistently.

The more severe cases show many sensitivities both to inhalants and foods. The less severe cases probably have many sensitivities but these are less easily demonstrable.

Treatment by avoidance or injection or both should be as complete as possible, and infections should be treated, especially with the antibiotics.

Treatment is more difficult than in older children, but the results in the long run are good, considering that many of these cases would become much worse if neglected.

OSTEOID OSTEOMA OF THE ASTRAGALUS

SAMUEL SPADEA, M.D.

The Author: *Samuel Spadea, M.D., of Providence. Chief, Orthopedic Section, U. S. Veterans Administration Hospital, Providence.*

OSTEOID OSTEOMA was not a recognized lesion until the advent of Jaffe's original paper in 1935. It is to him we owe credit for establishing this lesion as a distinct entity. Probably the first description of the pathological picture of this disorder was made by Bergstrand who, in 1930, described two cases and he was under the impression that the lesions, both clinically and pathologically were osteogenic sarcomas. Other investigators in the ensuing years have reported cases of osteoid osteoma.

In the October issue of the Journal of Bone and Joint Surgery of 1947, Dr. Mary S. Sherman of Chicago reported 30 additional cases of osteoid osteoma. In her paper she reviewed 158 cases of osteoid osteoma that were to be found in the literature and described the lesion as being predominantly found first in the tibia, then the femur and then the vertebrae, the astragalus numbering four on the list. It is noteworthy to observe that there are only 13 cases to date reported in the literature of this lesion of the astragalus.

Although the clinical picture of the disease has been reported before it is important to recall the physical findings of this disease; and it is only for emphasis in diagnosis that a brief summary of the chief symptoms of osteoid osteoma is now presented.

This disorder is much more common in the male than in the female. Of 127 cases that have been reported, 87 were males and the remainder females. The ratio of males to females is greater than 2 to 1. There has been only one case reported in the negro. Jaffe stated that the lesion has a predilection for adolescents and young adults. This has been verified by other workers.

The chief physical finding is that of tenderness, which usually can be definitely localized and which is exquisite in nature. The lesions in bones with little soft tissue covering may be accompanied by swelling; but rarely, if ever, are they warm, and never is the skin red. If the site of the lesion is near a joint, motion of that joint is often limited and painful. There is sometimes noted increased fluid in the joint space, and the findings may simulate a primary arthritis. In the spine, an osteoid osteoma produces all the signs of acute localized back pain, including associated muscle spasm and secondary postural imbalance. There are no systemic complaints or findings. The patients are afebrile and have normal blood counts. The X-ray picture of a mature lesion reveals a characteristic picture. There is an active nidus, which is usually small, round, or oval in shape, of reduced density. Within it one can see a small dense shadow, which represents ossification of the central portion. About this nidus is a thick dense shadow of sclerotic regional bone, and this bone is almost always present. If the lesion is at or in the cortex, the regional hypertrophy, especially along the periosteal surface, is much greater. The circumference of the shaft may be so greatly increased and the bone so sclerotic that the nidus is difficult to demonstrate by X-ray. The pathological picture is quite characteristic. One sees in the microscopic picture areas of cellular fibrous tissue, sometimes containing giant cells and many well-formed irregular trabeculae of osteoid tissue. Near the periphery of a section, sometimes one sees calcification of some of the trabeculae.

Treatment of osteoid osteoma is most satisfactory. For the immediate and permanent relief of symptoms, surgical excision is recommended.

Patient I. M., a 25 year old white male, was admitted to the Veterans Administration Hospital, Togus, Maine, on November 5, 1947, complaining of pain and swelling in the right ankle. He stated that in August 1945, he fell and turned his right ankle during an air raid in the Philippine Islands. There was considerable pain and swelling at this time. However, it subsided in a few days. Occasionally after that he would note mild pain and swelling after long walks or after standing long hours but not serious enough for him to consult a doctor. However, in February 1947, he began to notice almost daily occurrences of an aching pain in the ankle with a somewhat localized area of swelling on the inside of the ankle. This pain was particularly noticeable at night, frequently preventing him from falling asleep, or it would awaken him after he had fallen asleep. The pain and swelling had become progressively worse during the intervening months, so that in the past month or two it had caused him to limp slightly. Both the pain and the swelling were confined to a small area on the anteromedial aspect of the ankle.

There had been no known febrile episodes, nor were there any other symptoms.

Physical examination revealed a well developed, slightly built, undernourished white male, who was not acutely ill. Examination was entirely negative except for a moderate, diffuse, soft swelling on the medial aspect of the right ankle joint, just distal and anterior to the medial malleolus. This area was exquisitely tender to palpation, but there was no redness or increased surface heat. There was a normal range of motion except that forced eversion elicited pain. All of the routine clinical and laboratory examinations including urine, CBC, and Kahn test were within normal limits. Sedimentation rate was two mgms. per hour. X-ray of the chest was negative. A patch test for TB was negative. X-ray of the right ankle revealed an active nidus, small, round, about one cm., lesion of the astragalus. Within this nidus, was seen a small dense shadow, which represented ossification of the central portion. At this time we suspected that we were dealing with an osteoid osteoma of the astragalus, and an operation was performed.

Under spinal anesthesia, the right leg and ankle were prepared and draped in the usual fashion. A tourniquet was applied to the upper thigh, and a small curved incision was then made over the medial aspect of the ankle joint. The incision was directed through the subcutaneous tissue, through the joint capsule and synovial membrane, encountering a small circumscribed area, the size of a ten-cent piece, on the articular surface of the talus, on its medial aspect. This area was softer than the surrounding bone and was spongy and congested in appearance, pinkish and granular. On using a bone curette, the small area was excised in its entirety. The wound was then closed with interrupted black silk. A plaster cast was applied from the tibial crest to the knee down to and including the toes. A specimen of the lesion was sent to the laboratory. The pathological report follows: Gross appearance of the lesion showed a small nodule, granular and pinkish in color, surrounded by spicules of bone. The microscopic picture presented a central nidus of sclerosing bone, surrounded by osteoid tissue and a dense fibrous stroma. Following operation, the very next morning, the patient stated that his pain was completely gone and he felt very well for the first time in three years with complete relief of symptoms. He remained free from pain up to the time he left the hospital on January 29, 1948. A month later, after the patient had gone home, about February 28, a personal communication was received from the patient, stating that he still is enjoying very good health and has not had any recurrence of his pain.



Roentgenogram of right ankle. Arrow points to lesion of osteoid osteoma.

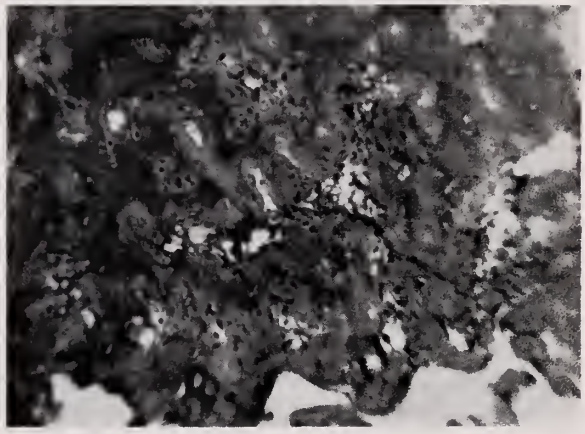


Photo microscopic picture of osteoid osteoma

Summary

A case of osteoid osteoma involving the astragalus of the right foot cured by surgical removal is reported.

This represents the thirteenth such case reported in this locality.

References

[1] Jaffe, H. L.: "Osteoid-Osteoma." A Benign Osteoblastic Tumor Composed of Osteoid and Atypical Bone. Arch. Surg., 31:709-728, 1935.

[2] Bergstrand, Hilding: Uber eine eigenartige, wahrscheinlich bisher nicht beschreibene osteoblastische Krankheit in den langen Knochen der Hand und des Fusses. Acta Radiol., 11:597-613, 1930.

[3] Sherman, Mary S.: Review of the Literature and Report of Thirty Cases of Osteoid Osteoma. J. Bone and Joint Surg., 29:918-930, October 1937.

SYMPATHETIC NERVE BLOCK

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SYMPATHETIC nerve block is a paravertebral injection of the sympathetic nerves or their ganglia. It is a comparatively new therapeutic and diagnostic procedure. Since the original work of Lawen (1923) with procain and Swetlow (1926) with alcohol in blocking sympathetic nerve fibers, there has been only a mild interest in this valuable form of therapy. Many patients with an intractable type of burning or aching pain following an injury of some kind to an extremity can now receive spectacular relief by blocking abnormal sympathetic reflex mechanisms. The procedure has been simplified in order to obtain the maximum sympathetic response with minimum amount of discomfort to the patient. Blocks for upper extremities are obtained by injecting the proper fascial plane in the neck (region of fifth cervical vertebra) in order to infiltrate the stellate ganglion. This technique eliminates the danger of pleural puncture that may occur if the stellate ganglion were injected directly. The successful use of stellate ganglion block for cerebral thrombosis has been reported in the literature[1]. Blocks for lower extremities are made paravertebrally by a dorsal approach. The patient's discomfort can be minimized if the operator refrains from hitting the periosteum of the body of the vertebra too many times.

The anesthetic solution that will give the more lasting effect with least toxicity is the one desired. In our hands *Metycaine 1½% has given us better results. This was particularly noted in our previous paper on brachial blocks[2]. The total amount of solution should be kept at a minimum to prevent infiltrating adjacent somatic nerves. A stellate block requires only 5 c.c. of solution and a lumbar sympathetic block, 10 to 20 c.c.

Reflex Sympathetic Dystrophy

Severe pain of an extremity following war injuries was first described during the Civil War by Weir Mitchell. He called this post-traumatic syndrome a Causalgia. Since that time, the same clinical syndrome has been described as reflex sympathetic dystrophy, post-traumatic dystrophy, shoulder-hand syndrome[3] and in far-advanced cases with bony changes, it is called traumatic osteoporosis or Sudek's atrophy.

The cause of this syndrome is trauma but the severity of this trauma may vary from a simple bruise to a crushing injury of an extremity, resulting in a hyperactive sympathetic reflex as shown by vasomotor and trophic disturbances. Other immediate types of injuries may be herpes zoster, frost bite, thrombophebitis or chronic occupational strain.

In those cases in which the pathological process persists, the condition becomes progressively worse resulting in varying degrees of pain, but the vasomotor and tropic disturbances become more severe. The skin of the extremity will become mottled, cold and sweaty, or it may be hot at the onset with some subcutaneous edema. Then atrophy of the skin with fibrosis of muscles and stiffening of the joints may follow. The fingers will become thin and tapering. If the condition continues, atrophy of the bone will result, giving the x-ray a moth-eaten appearance.

It appears that the patients' emotional instability such as nervousness, excessive sweating and tachycardia is more closely related to sympathetic dystrophy, rather than the severity of the injury.

Although sweating is a salient feature of these sympathetic hyperactive states, it is well-known that an injection of adrenalin will not produce this in a person. The reason for this has been shown by Dale and Feldbert (1934) who noted that post-ganglionic sympathetic fibers to sweat glands are cholinergic. Thus, atropine, which is a para-sympathetic inhibitor, can abolish the sweating by blocking the cholinergic transmission.

Raynaud described a syndrome in 1862 which now bears his name. White and Smithwick[4] agree with his theory of vaso-constriction due to sympathetic over-activity but Sir Thomas Lewis prefers to attribute the origin to a local action in the musculature of the blood vessels. In Raynaud's Disease, the diagnosis should be confirmed by a sympathetic nerve block and the treatment required

* *Appreciation is extended to Eli Lilly Co. for an experimental supply of Metycaine that was used in these cases.*

is a sympathectomy. If the sympathetic block is unsuccessful, the sympathectomy is not likely to prove successful[5].

Oschner and De Bakey[6] (1941) have recommended the use of sympathetic blocks to relieve the venous and arterial spasm in thrombophlebitis. White and Smithwick have used sympathetic blocks for hyperhidrosis (excessive sweating). Similar blocks have been used successfully for herpes zoster by blocking the sympathetics at the level of the involvement. Phantom limb has been treated by sympathetic blocks, but not all patients are benefited by this procedure.

The physiology in these disturbed states is not clear. Livingston[7] has described the internuncial pool in the spinal cord, resulting in a barrage of impulses from a focus of irritation, as an explanation of the abnormal state. Some authors have attempted to inject the focus of irritation or the trigger point without conclusive evidence that the same disturbed dysfunction occurs in every situation. This abnormal sympathetic excitation or exaggerated reflex is located within the internuncial pool and must be interrupted by a sympathetic block. In those cases that are successfully treated with sympathetic block, each sympathetic block will be followed by a longer interval of relief. The original block may interrupt the vicious sympathetic cycle for two or three hours and the next one may last the entire day, until it will be noted that the patient will get relief for two to three weeks after his fourth or fifth block. The sympathetic blocks should be repeated at longer and longer intervals of rest but should not be delayed long enough for the sympathetic over-activity to return. It has also been found that a single sympathetic block may permanently interrupt this over-activity. On the other hand, if each successive sympathetic block gives only the same short period of relief, then it must be assumed that a sympathectomy is required to permanently knock out this sympathetic bombardment.

The skin temperature changes following sympathetic blocks are variable, depending on the degree of vasomotor disturbance. The average skin temperature rise, following a block in a normal extremity, is about eight to ten degrees. In those conditions with cold, clammy extremities, the rise may be from twenty to twenty-five degrees. In the hot and swollen extremities, there will be little or no temperature rise and therefore is no indication of the success of a block. Thus, either a skin temperature rise of twenty degrees or the spontaneous relief of pain is a good indication of the presence of sympathetic over-activity. Both responses may or may not occur together. Pharmaceutical houses have recently publicized certain drugs claiming autonomic and sympatholytic action for this condition. The results are not convincing. In my experience, satisfactory results were not obtained in the presence of these drugs until sympathetic nerve blocks were administered.

The following are summaries of case histories in which only the salient features have been included.

CASE I — Mrs. M. D. Age 54

Seen with painful Herpes Zoster in region of right breast and axilla of eleven days duration. Patient had been treated with Vitamin B both by mouth and intramuscularly without improvement. Codeine and Demerol were required to ease the pain.

Patient was given a right dorsal sympathetic block at T2, T3 and T4 with immediate relief of pain which lasted five days. The patient received her second sympathetic block which relieved her for ten days. She was blocked three times more on alternate days and at the end of her injections, patient admitted relief of the intense pain although a mild soreness persisted. The treatment had no effect on the herpetic rash.

CASE II — Mrs. J. H. Age 45

Patient was seen seven months post-operatively following a radical breast amputation on her right side. There was burning pain of the wrist and forearm and swelling of the entire extremity including the fingers. Hyperesthesia was present. The color, temperature and radial pulse were the same in both arms. This patient was given a right stellate block with immediate relief of pain. Temperature rise was only minimum. This was the first relief from pain since her operation. Four days later the patient noted the complete loss of edema and the continued absence of her previous pain. Thereafter, the stellate blocks were continued at weekly intervals for three more times and the patient continued to be symptom-free. The edema of the extremity did not return.

CASE III—Mrs. H. M. Age 69

A controlled diabetic was seen with burning pain in left foot with a large ulcer (size of half dollar) on her heel. A similar condition started in her right foot nine months ago which steadily grew worse, requiring amputation at the mid-thigh. Patient now refused any type of operation. Repeated sympathetic blocks were done at D12, L1 and L2 for her left leg with rapid improvement. The edema disappeared completely, the pain was relieved and the ulcer healed to the size of the head of a pencil. It is four months now since her original visit and the patient returns periodically for a sympathetic block when there is evidence of the return of her burning pain or swelling.

continued on next page

CASE IV — Mrs. E. S. Age 54

Patient seen with a post-herpetic neuralgia of ten weeks duration involving the distribution of the third thoracic nerve on her right side, requiring large doses of morphia. There was a history of herpetic lesions of the skin but at present, the only evidence was a pigmented linear distribution. Patient was given a dorsal sympathetic block at D2, D3 and D4 with immediate relief of pain lasting twenty-four hours. Each successive block gave longer and longer periods of relief. At the end of her sixth block, the pain had completely disappeared. However, five weeks later, the patient returned complaining of severe pain, this time, along the sixth thoracic nerve on the same side. There was no skin erruption. Three more blocks at five day intervals relieved her pain and patient has been symptom-free for four months.

CASE V — Mrs. A. W. Age 39

Patient seen with a post-traumatic sympathetic dystrophy, stage 1, of right wrist and forearm. Patient has been treated for past two years, following severe trauma to right wrist, with diathermy, whirlpool baths and splinting in a plaster cast. Patient complained of a "tooth ache" type of pain with coldness and sweating but no burning. Patient was given a series of right stellate blocks, anterior approach, at C5 with typical Horner's Syndrome resulting each time. After each block, patient received longer and longer periods of complete relief of her pain. Patient began to pronate and suppinate her hand freely without the distress she noted previously. After her sixth block, it was noted that patient had complete relief for seven weeks and she could go about her household duties without distress. Patient now has gone twenty-one weeks without pain, following her tenth stellate block.

CASE VI — Mrs. E. T. Age 49

A controlled diabetic was seen with post-thrombophlebitic sympathetic causalgia of right thigh. She complained of an ache and at times a burning pain of her right thigh for the past seven months, especially after walking. Patient was given a series of three sympathetic blocks at D12, L1 and L2 with immediate relief of pain. Skin temperature readings showed a 13 degree rise in her foot following the blocks. Patient continued to have complete relief for four months without further blocks, after which time patient complained of a mild recurrence of the pain. She was given two more sympathetic blocks at five day intervals with complete disappearance of her pain. Patient has now been symptom free for seven months following her last block.

CASE VII — Mrs. H. W. Age 63

A controlled diabetic seen with pain in left foot with a gangrenous big toe involving the distal phalanx. No pulsation could be felt in the foot. One year ago, patient had a similar picture of her right foot and she had a right sympathectomy done without any benefit. The gangrenous big toe became worse and she was subjected within a short time to a mid-thigh amputation. In spite of advice by surgeons to have another sympathectomy on her left side with a trans-metatarsal amputation for this new episode, she refused any type of surgical intervention. The unsuccessful results of the sympathectomy on her right side was a bitter experience for her. However, she consented to a short series of sympathetic blocks. On the basis of encouraging a rapid collateral circulation, she was given left lumbar sympathetic blocks at D12, L1 and L2. There was no appreciable rise in skin temperatures but there were longer and longer periods of relief of her pain. At the end of her seventh sympathetic block, it was noted that her foot was warmer and the gangrenous big toe had sloughed off and fresh granulations were forming beneath. Soon the skin edges healed over, leaving a small draining sinus. The pain had disappeared and the patient began to walk on crutches. Her injections were continued with longer intervals between each sympathetic block. At present, patient returns every eight weeks for a sympathetic block. It is seventeen months since her original visit. She now has full use of her left leg and is ambulatory with the aid of an artificial right limb.

CASE VIII — Mrs. M. F. Age 32

Patient seen with post-traumatic sympathetic dystrophy, stage 2 right foot, with story of an injury ten months ago. She complained of coldness and swelling of right ankle and foot, but no sweating. Patient had been treated with whirlpool baths and for the past six months was wearing a cast with no improvement. She was given a sympathetic block at D12, and L1 on right side with immediate relief. Skin temperature readings showed a temperature rise of 17 degrees in that foot. This was repeated every fifth day and it was noted after her fourth block that her symptoms had not returned and the ankle swelling had completely disappeared. Further treatment was discontinued and there was no recurrence of her pain. She has now been symptom free for the past thirteen months.

CASE IX — Miss M. J.

Patient was seen with a sympathetic causalgia of right lower leg and foot with coldness and swelling of two years duration. Patient had received an open reduction for a compound fracture at that time and since then complained of a throbbing and burning pain even while at rest. X-rays showed

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REMOVAL OF A MALIGNANT KIDNEY TUMOR THROUGH A THORACO-ABDOMINAL INCISION

Report of a Case

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WILLIAM A. MCDONNELL, M.D., and JOHN E. FARLEY, M.D.

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THORACO-ABDOMINAL APPROACH to kidney tumors was developed and first reported in this country by Chute and Soutter[1] of Boston. However, a single case in 1946 was operated by this route, unknown to Chute and Soutter, and reported in the American Journal of Urology by Mortenson[2] of Australia in December, 1948.

Thoraco-abdominal nephrectomy offers the following advantages:

1. Excellent exposure, which greatly facilitates nephrectomy in difficult large kidney tumors. In such cases the blood supply is very rich, and tumor tissue readily spreads, especially through the renal vein. The vein and entire pedicle is readily delineated and may be easily ligated without handling the tumor mass.

2. The perirenal fat pad is removed intact with the kidney, and local lymphatic metastasis, which is very common in kidney tumors by the time they are diagnosed and operated, may be removed. This is in contrast to the lumbar approach, which offers no such opportunity. In a series reported by Chute and Soutter in December of 1949, all but 8 of 20 cases showed such local metastasis.

The following is a report of a case in which this technic was used:

M. C., a 61 year old white married female, was admitted to St. Joseph's Hospital on 12/19/49 complaining of weakness, vomiting, and weight loss. The patient stated that she was well until approximately one year prior to admission, when she noted weakness, drowsiness and fatigue. She consulted her family physician four or five months prior to admission because of increased severity of symptoms and the onset of occasional nausea and regurgitation. She had lost 18 pounds in the last eight months. A gastro-intestinal series was performed outside the hospital and was not remarkable except for pylorospasm. A mild hypochromic microcytic anemia was also discovered. She had received liver and iron but had not responded to treatment. Her appetite was only fair, but there was no disturbance in bowel habits. It was further revealed that two months prior to admission she had retention and hematuria on one occasion. There were no other complaints.

The past history showed the usual childhood diseases. There were no previous serious illnesses, operations, or injuries.

The family history was non-contributory.

The system review was essentially negative.

On physical examination the patient was a pale, fairly well developed, poorly nourished, white, middle-aged appearing female in no acute distress. The skin was pale, but was clear, cool, and dry. Her pupils were round, regular, equal, and reacted to light and accommodation. Sclerae were clear. The conjunctivae were pale. She appeared to have incipient cataracts bilaterally. Ophthalmological examination essentially negative. Nose and ears were without abnormality. There was edentia. Her tongue was reddened but not smooth. The throat was clear except for minimal injection in the right posterior pharynx. Her neck was supple. There were no glands palpated. The thyroid was not palpable.

The chest and lungs were clear to percussion and auscultation. The heart was normal in size, rate and rhythm. There was a Grade I apical systolic murmur, not transmitted.

Palpation of her abdomen revealed a mass slightly movable, firm, the size of an orange in the left upper quadrant. The abdomen was otherwise without abnormality.

The neuromuscular system showed no abnormalities. There was no limitation of joints. There was one plus pitting edema of her ankles bilaterally. There were no palpable glands.

Initial laboratory work showed an essentially normal urine. Blood studies: Hematocrit of 27 mm. with a Sahli hemoglobin of 60% or 9.36 grams; white count 9,800; red count 3,450,000; with a differential of 78 neutrophiles, 18 lymphocytes, 3 monocytes and 1 eosinophile. The mean corpuscular volume was 79, and the mean corpuscular hemoglobin 23. The mean corpuscular hemoglobin

continued on next page

concentration was 22. The fasting blood sugar was 90 mgs. Blood urea nitrogen was 16.3 mgs. Chlorides 536 mgs. Blood protein 3.69 gms. Albumin 2.80 gms. and globulin of 0.89 gms.

X-ray examination of the chest revealed minimal sclerosis of the aortic arch. The lung fields were clear. Examination of the renal structures by KUB film revealed the right kidney to be normal in size, shape and position. There was a marked enlargement of the upper half of the left kidney. Film after the intravenous injection of the dye revealed the calices, pelvis and upper portion of the right ureter to be well visualized. The lower portion of the right ureter was not visualized at any time. On the left side only the lowermost calices were visualized at any time. No dye was seen in the upper distended portion of the left kidney. CONCLUSION was that the findings were consistent with a large tumor mass in the upper left kidney which was most probably neoplastic although the possibility of a cyst could not absolutely be ruled out.

Examination of the large bowel by barium enema revealed no evidence of bowel pathology.

Examination of the skull revealed an area of increased bone density in the right frontal bone which measured approximately 1½ x 2 cm. in size. It did not have the usual appearance of metastasis but was osteoblastic in character. However, the possibility could not be ruled out. The lesion had more of the appearance of an osteoma. There was no other evidence of pathology in the skull.

Examination of the pelvis and lumbosacral spine revealed no evidence of metastasis.

Bone marrow studies performed revealed essentially no pathology.

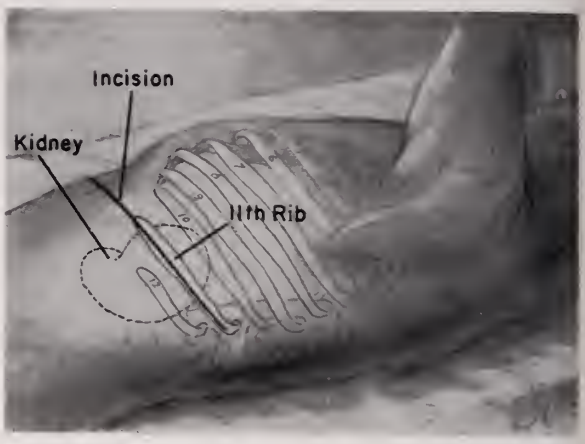
The patient was given four whole blood transfusions totalling 2,000 cc. over a period of two weeks with a response demonstrated by counts which revealed 85% Sahli hemoglobin; 11,350 white blood cells; 4,350,000 red blood cells; with a differential of 65 neutrophiles, 26 lymphocytes and 5 eosinophiles. Her serum protein also responded with a total of 6 grams and albumin of 4.35 grams and globulin 1.65 grams.

The patient was operated on 23 days after admission.

Operative and Anesthesia Technic

The patient was medicated with Pantopon Grs. 1/6 and Scopolamine Grs. 1/150, 1½ hours preoperatively and Nembutal Grs. 1½, 1 hour preoperatively. Cyclopropane anesthesia started, followed by ether.

The incision started from a point about 1 cm. lateral to the spinous process and was extended downward over the 11th rib and continued anteriorly in the same direction, to the lateral border of the rectus muscle. The next step was a complete subperiosteal resection of the 11th rib. Complete re-



section of the rib is essential to maximum exposure, which is the fundamental purpose of this type of incision. The pleura was opened cautiously through the periosteal bed of the resected rib, caution being taken not to injure the lung. In this instance there were no adhesions present. A moist "walling off" strip of gauze was placed carefully to protect the lung, which was kept about 80% expanded. The phrenic nerve was located passing down over the pericardium, but in this instance the decision was made not to crush the nerve. Next, the diaphragm was opened in line with the incision. This incision was carried anteriorly through the obliques and transversus abdominus muscles until the lateral border of the rectus was reached. A spreading retractor was placed in the wound between the 10th and 12th ribs. The tumor mass together with the spleen bulged directly up in the center of the wound. The spleen in this case was enlarged and the decision was made to remove it. The colon was carefully freed from the tumor mass and a large, thickened, tumor-filled renal vein was exposed. This tumor mass in the vein was gently milked back, it having extended to the vena cava, and the vein was then carefully ligated and sectioned. The artery was then sectioned after being carefully ligated. A large and entirely separate second renal vein going to the upper pole of the kidney was clamped and ligated. The original renal vein in this instance was non-functioning and packed solidly with tumor tissue. There was no tumor tissue in the functioning anomalous renal vein. The ureter was clamped, ligated and sectioned below the uretero-pelvic junction. The entire tumor mass with its perirenal fat pad was removed. In this case there were a few peri-aortic lymph nodes present and these were dissected free and removed. Closure was then carried out. The peritoneum was closed with a running #1 plain catgut suture. The diaphragm was closed with interrupted heavy silk sutures. The pleura was closed with interrupted silk sutures. The last two sutures in the pleura were not tied until the lung was completely ex-

panded. The muscles were closed with interrupted #1 chromic sutures and the skin with silk.

The specimen was described grossly as a mass 16 cm. in length, 13 cm. in thickness and 10 cm. in width. In the hilus was a lobulated, pale brown, firm tumor mass with the kidney extending over its surface like a crescent. The tumor had invaded the kidney parenchyma throughout its upper and mid-portion. A portion of the tumor was found within the renal vein at the hilus. Microscopically the neoplasm was a typical hypernephroma. The spleen showed increased endothelial hyperplasia and hemosiderin deposits.

Postoperatively the patient was placed in oxygen by nasal catheter to decrease the respiratory excursions as much as possible and to supply the functioning pulmonary tissue with as much aeration as could be administered, and finally, for supportive reasons. The patient's convalescence was rapid and satisfactory. The catheter into the pleural space was removed four days postoperatively. A chest plate the day before discharge revealed pleuritis at the left base. Because of the possibility of pleural metastasis, a follow-up film five months postoperatively was taken and revealed no evidence of pathology in the chest. Repeat skull films were interpreted as showing a benign osteoma.



Post Operative Scar

The patient has returned for periodic examinations to the Out-Patient Department and has had no complaints at any time. The wound healed well and the patient has gained thirty pounds. Blood chemistry is within normal limits, the urine shows no abnormalities, and the hemogram is satisfactory.

Summary

A report of hypernephroma removed by the thoraco-abdominal approach, a relatively new procedure, has been presented. The advantages of this approach are excellent exposure and better opportunity to remove local metastatic tissue involved.

References

[1]H. Mortensen—Journ. of Urology, 60-6;855 Dec. '48.
[2]R. Chute & L. Soutter—Journ. of Urology, 61-4;688 April '49.

SYMPATHETIC NERVE BLOCK

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good union of bones. Patient was given right lumbar sympathetic blocks at D12, L1 and L2 with immediate relief. A series of blocks showed that each block gave her relief for only two days and her original symptoms would return. Because there was no increase in time interval of the relief of pain following each block, it was considered wise to submit this patient to a lumbar sympathectomy for permanent relief of her causalgia. Following the operation the patient remained symptom-free.

Summary

An attempt has been made to present a short series of cases of Sympathetic Causalgia or Dystrophy with typical results following sympathetic nerve block. The results from these blocks have been gratifying. However, it is not inferred that sympathetic block should replace sympathectomy, but it is reasonable to suggest that such patients as above presented, should be given a fair trial of sympathetic blocks before surgery is considered. It has previously been reported that a sympathetic block that gives longer and longer periods of relief following each injection is a good indication that the block alone will ultimately eliminate the sympathetic condition[13]. However, if each bock gives relief for only a few hours, it is fair to assume that the condition is caused by sympathetic hyperactivity and a sympathectomy must be done to give permanent relief.

Then again, there are conditions which must be treated with sympathetic blocks alone, either because of poor operative risks or because of refusal by the patient to undertake a surgical procedure.

A sympathetic block by a competent physician is a relatively easy procedure. However, in unskilled hands, the block can be readily missed and false conclusions may be drawn from the lack of sympathetic response.

Progress has been made in this field, both in knowledge and technique, and surgeons may now have confidence in the value of diagnostic and therapeutic blocks in the hands of competent anesthetists.

Bibliography

[1]Gilbert & De Takats: Treatment of Apoplexy. J.A.M.A., March 1949
[2]Damarjian, E.: Brachial Blocks (100 Consecutive Cases). R.I.M.J., April 1946.
[3]Steinbrocker, O.: Shoulder-Hand Syndrome. Ann. Rheum., Dec. 6, 1949.
[4]White & Smithwick: Autonomic Nervous System. McMillan, 1948.
[5]Evans, J.: Reflex Sympathetic Dystrophy. J.A.M.A., Nov. 1946.
[6]Oschner & DeBakey: Sympathetic Block in Thrombophlebitis. Ala. M.J. 11, 1941.

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NUCLEAR THERAPY

PRESENT DAY knowledge of the release and control of atomic energy has brought civilization a previously unrecognized power over a vast new range of natural phenomena. The eventual potential of this newly gained control is beyond estimation at present but the very small part that is clearly seen holds high hopes for benefiting mankind in many fields, not the least important of which is medicine.

The development of improved methods for securing nuclear changes in the atom, producing radioactive isotopes which are now so useful in the solution of many of our biological, chemical and pathological problems, gives us a far greater scope of application of the various products of nuclear energy. This is due to the fact that large quantities of a majority of all the known artificial radioelements can now be produced and the adaptation of these substances to the medical and biological sciences falls into the tracer type of investigation and the more important therapeutic use of these agents.

The latter while as yet only meagerly explored, has demonstrated that phosphorus for example has proved valuable in the treatment of such conditions as leukemia and polycythemia vera. The use of radioactive iodine in the treatment of thyroid disease, both hyperthyroidism and certain types of thyroid cancer, has recently revealed the possibility of this agent as superseding surgery in the therapy of disturbed thyroid metabolism, fulfilling a prediction made a decade ago by Dr. Frank H. Lahey.

The present status of the value of these materials in the treatment of disease is still largely experimental. Local experience conforms with data accumulated in larger centers in that it is too early to lay down definitive procedures and rationalize therapy for specific diseases.

While the isotopes of only two elements have proved to be therapeutically useful, namely the radioisotopes of iodine and phosphorus, we are in the midst of enormous developments out of which will evolve an entirely new era of knowledge of the fundamental chemical processes of the body through employment of tracer elements provided by nuclear energy.

It seems difficult to realize that more than a decade has passed since the earliest use of activated iodine in rabbits was demonstrated by Hertz in Boston to show that the pick-up of iodine could reach a level in overactive thyroid glands several hundred times that found in normal tissues. The use of radioactive iodine was a logical sequel to these experiments so that on the basis of well established data, approximately three-fourths of all patients suffering with thyroid disease can be controlled in this manner thereby eliminating the hazards so long known to be associated with the surgical treatment of this disease.

Control of hyperthyroidism in this way is no longer open to debate, but the application of this element in the treatment of thyroid cancer presents

a much more unsettled problem since malignancy and precise methods for measuring the functional difference of cancer cells even in the thyroid, await further study.

Extended application of these newer principles of therapy to other disease entities awaits only clinical confirmation of careful experimental effort particularly in the field of cancer control whatever the site of its origin. The stimulus of present day achievements gains further impetus when it is realized how great the progress of the past half century has been since the French in 1740 established the first hospital for the exclusive treatment of patients with cancer and the British in 1802 formed in London the "Society for Investigating the Nature and Cure of Cancer."

The future holds extraordinary promise, and without engaging in speculation, it seems safe to say that the role of Nuclear Therapy with its development of isotopes from an ever increasing knowledge of atomic energy provides us with realistic hope for newer and better methods of radiation therapy in the control of malignant disease processes that will rank equally with our recent conquest of pyogenic agents through antibiotics.

A M A MEMBERSHIP AND FELLOWSHIP

THE ACTION of the House of Delegates of the American Medical Association at the San Francisco session in clarifying the issues regarding dues for AMA membership and fellowship should meet with the approval of every physician.

The necessity for annual dues had been fully established a year ago. But there was both confusion and misunderstanding regarding the assessments for membership, fellowship, and Journal subscriptions. The problem has received the attention of many state associations in the intervening year, and as a result it was resolved satisfactorily at San Francisco.

Starting in 1951 all dues paying members of the American Medical Association will receive as part of the dues a subscription to the Journal of the AMA. Presently the Journal subscription is an additional $12 to the $25 dues. Including the Journal in the dues should effect a better understanding of the work of the AMA, for many physicians who do not now subscribe to the Journal will henceforth receive issues weekly of what is beyond question the outstanding medical publication in the world.

Fellowship in the Scientific Assembly has been preserved, but the dues have been reduced from $12 to $2. Fellows may elect to take a special journal in lieu of the Journal of the AMA which they would ordinarily receive as members. This privilege, however, is not extended to members who are not Fellows of the Scientific Assembly.

EDUCATION FOR GENERAL PRACTICE

The report to the trustees of the American Medical Association by the deans of three of our major medical schools who spent two months in Great Britain studying the current status of medical education there is worthwhile reading. The committee gave particular attention to the impact that the British National Health Service is having, or seems likely to have, on medical education.

The conclusions of the committee, together with some of the major reasons for these conclusions, compile a sizeable report. One conclusion, however, warrants our attention at the moment, as it concerns the education of the general practitioner. It is reported as follows:

> "Undoubtedly one development in British medical education which causes great concern has been markedly exaggerated by the National Health Service Act. That is that almost all students and recently graduated physicians want to become specialists. Even before the Act the last of the general practitioner in Britain was not too happy and today is demoralizing. We do not refer to overwork, but rather to the fact that he seems destined to a routine life which does not offer the necessary facilities to practice good medicine and which fails utterly to offer the professional incentives which lead to continued growth of the physician.
>
> "Your committee has seen what happens when the division between specialist and general practitioner becomes decisive, and we most earnestly hope that American medical schools will carry forward the movement that has appeared since the war, and will continue to develop superior hospital training designed to prepare physicians for the general practice of medicine on an ever-enlarging scale. If we really believe that the general practitioner is the 'backbone of medicine', then let us prepare him for the most difficult task in medicine. After our experience in England we are confident that this is the most important job facing the medical schools of the United States during the next decade."

We hope that the medical schools in this country will heed this advice. We are encouraged by the general public interest, as well as professional support, of the general practitioner in the past few years. The movement to have general practice sections as part of the hospital staff, and the rapid growth of the American Academy of General Practice which requires continuing postgraduate training of its members, are movements in the right direction.

ABERRANT THYROID TISSUE

IN THE DIAGNOSIS of abnormal swellings on the tongue, or in the cervical region, or within the upper part of the thorax, it is sometimes forgotten that thyroid tissue, like adrenal, splenic and occasionally pancreatic tissue, is prone to aberrations in localization. It is well-known that retromanubrial masses of thyroid tissue are not uncommon, and that if they become sufficiently bulky they may exert sufficient pressure on the trachea to cause dyspnea. It is perhaps less well-known that small masses of aberrant thyroid tissue may occur within the trachea itself, may be situated at the base of the tongue, forming smooth, centrally-located, rounded tumors, and may occur in almost any part of the neck other than the area occupied by the normal gland. Lack of knowledge of these facts is apt to lead to errors in diagnosis and if, as occasionally happens, patients with such aberrant masses of thyroid tissue are the victims of hyperthyroidism, failure to remove the misplaced thyroid tissue may, even after a subtotal thyroidectomy, fail to relieve the symptoms of abnormal activity of the gland.

Another situation which must be considered in connection with the diagnosis of displaced thyroid tissue, because it may lead to error, is the fact that there is a type of malignant adenoma of the thyroid which histologically closely resembles normal thyroid tissue and which may metastasize to the cervical nodes or, not infrequently to bones, usually those of the cranium. One misleading peculiarity of this form of thyroid neoplasm is that the original growth in the thyroid is frequently so small that it may be overlooked. A thyroid nodule only a few centimeters in diameter may not be noted, though if the larger metastases are surgically removed their close resemblance to thyroid tissue may lead an alert surgeon to explore the gland and discover and remove the primary growth. This particular type of thyroid neoplasm is not usually highly malignant and a good many patients afflicted with it may recover after surgical intervention. One wonders whether the radioactive isotope of iodin might not possess curative value in such cases. The discussion of the subject should recall the possibility that in connection with certain glands, some of which have already been mentioned, one must never forget, particularly in solving diagnostic problems, the possibilities of enlargement or even neoplasm of aberrant tissue.

G.B.

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MORNING SESSION

George W. Waterman, M.D., *Presiding*

10:30 a.m. CANCER OF THE LUNG
J. Gordon Scannell, M.D., Massachusetts General Hospital

11:00 a.m. APPROACH TO EXPERIMENTAL CANCER CHEMOTHERAPY
Joseph Leiter, PH.D., Bethesda, Maryland

11:30 a.m. RADIOACTIVE ISOTOPES IN CANCER DIAGNOSIS AND TREATMENT
Oliver Cope, M.D., Boston

12 noon CANCER OF THE STOMACH
Francis D. Moore, M.D., Boston

12:30 - 1:30 LUNCHEON IN BASEMENT DINING ROOM

1:30 p.m. BREAST CANCER—THE PROBLEM OF EARLY DIAGNOSIS
(Motion Picture)

* * *

AFTERNOON SESSION

Herman C. Pitts, M.D., *Presiding*

2:00 p.m. EARLY DIAGNOSIS AND TREATMENT OF BRAIN TUMORS
Arthur Elvidge, M.D., Montreal, Canada (Montreal Neurological Institute)

2:30 p.m. TUMORS IN CHILDREN
Harold W. Dargeon, M.D., New York City (Memorial Hospital)

3:00 p.m. CANCER OF ORAL CAVITY
Daniel Catlin, M.D., New York City (Memorial Hospital)

3:30 p.m. CANCER OF THE BREAST
Herbert W. Meyer, M.D., New York City (Bellevue Hospital)

4:00 p.m. ROUND TABLE DISCUSSION

BY-LAWS OF THE RHODE ISLAND MEDICAL SOCIETY

As Amended to MAY 11, 1950

RULES and BY-LAWS

ARTICLE I — NAME

The name of this organization is the RHODE ISLAND MEDICAL SOCIETY.

ARTICLE II — OBJECTS

The objects of this Society are to promote the science and art of medicine and the betterment of public health; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the problems of medicine.

ARTICLE III — MEMBERSHIP

SECTION 1. *Classes of Members.* — This Society consists of (a) Fellows, (b) honorary members, (c) and non-resident members.

SECTION 2. *Fellows.* — The Fellows are all the active members in good standing in the component societies from whom or on whose behalf the required annual dues or special assessments have been received timely by the Treasurer of this Society, and Fellows who may be elected in accordance with section 6 of the Charter.

SECTION 3. *Honorary Members.* — The honorary members are persons elected as such by the General Session on the nomination of the Council, provided, a physician resident in and practicing in Rhode Island shall not be eligible for honorary membership.

SECTION 4. *Non-resident Members.* — Any Fellow who has removed from Rhode Island and who desires to retain membership in this Society may become a non-resident member without assessment and without the privilege of voting upon notifying the Secretary, provided that his dues have been paid for the current year.

SECTION 5. *Rights of Fellows and Members.* — Fellows who are in good standing are entitled to all the rights, benefits and privileges of this Society, including the right to register at sessions of the Society, to attend and participate in the general meetings held therein, to vote, to hold office, subject to the qualifications set by these Rules and By-Laws for particular offices, to serve on committees, and to receive a copy of the Society's official publication as issued. When a Fellow resigns or loses his membership in a component society or dies he, or his estate, as the case may be, forfeits all right and title to any share in the privileges and property of this Society. The only rights possessed by honorary members and non-resident members are to register at sessions of the Society, to attend general meetings held therein, to serve on committees, and to receive a copy of the Society's official publication as issued.

SECTION 6. *Good Standing.* — A Fellow is not in good standing within the meaning of these Rules and By-Laws:

(a) Unless payment of dues and special assessments on his behalf have been received by the Treasurer as provided in these Rules and By-Laws;

(b) if he has been suspended or expelled by his component society, regardless of whether he has pending an appeal from such disciplinary order to the Council of this Society or to the Judicial Council of the American Medical Association; or

(c) if his license to practice in this or any other State has been revoked or suspended and has not been subsequently restored on appeal.

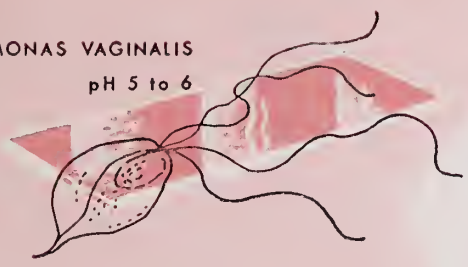
SECTION 7. *Dues.* — On or before January 1 of the year for which the dues in question are payable, each Fellow shall be assessed as annual dues such sum as the House of Delegates of this Society may have determined at its meeting in September immediately preceding. Said dues shall be paid to the Treasurer of the Rhode Island Medical Society, or to the treasurer of the Fellow's component society. The treasurer of the component society shall by the tenth of each month forward to the Treasurer of this Society dues collected from members during the preceding month. Any Fellow with respect to whom dues for that year have not been received by the Treasurer by December 31, after 60 days notice by the Treasurer shall be suspended from membership in this Society until such time as the current dues are received and the records of the Treasurer with respect to the payment of dues shall be prima facie evidence of the correctness of the facts stated therein.

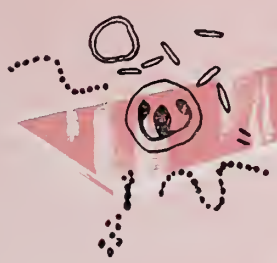
Fellows having attained the age of sixty-five years shall, if they so request, be exempt from payment of dues.

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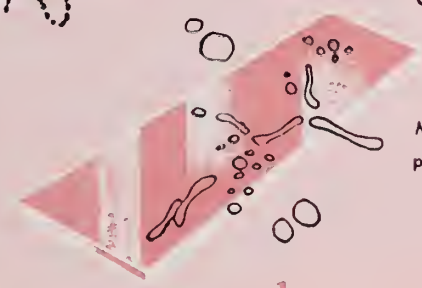


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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

BY-LAWS

continued from page 476

ARTICLE IV — COMPONENT SOCIETIES

SECTION 1. *Defined.* — The component societies of this Society consist of those district medical societies which hold charters from this Society that are in full force and effect.

SECTION 2. *Charters.* — (a) All charters issued by this Society continue in full force and effect until revoked or suspended.

(b) The Council, with the approval of the House of Delegates, may charter as a component society a medical society representative of the medical profession of a county or district as circumstances may dictate or as seems desirable.

SECTION 3. *Qualifications of Members.* — Subject to the provisions of section 4 of this Article, each component society is the sole judge of the qualifications of its members and the acceptance of applicants is wholly at the pleasure of the component society. A component society may create classes or types of membership in addition to the types of membership of this Society but only such members of the component society as possess the qualifications required by these Rules and By-Laws are Fellows of this Society.

SECTION 4. *Limitations.*—Component societies are subject to the following limitations:

(a) The Rules and By-Laws of this Society, and the amendments thereto that may be adopted in the future, are the supreme law of the component societies. In so far as the Constitution or By-Laws of this Society, the Constitution or By-Laws of the component society are void and of no effect.

(b) A component society may admit to active membership or continue in such membership only such physicians as (1) are licensed to practice medicine and surgery in Rhode Island, (2) reside or practice in the territorial jurisdiction of the society, except as the Rules and Regulations of this Society may otherwise provide, (3) abide by the Code of Ethics of the American Medical Association, and (4) do not practice or claim to practice any school or system of sectarian medicine or healing.

(c) A member against whom disciplinary action has been voted by a component society shall have the right to appeal to the Council of this Society and eventually to the Judicial Council of the American Medical Association under such rules as those two bodies may adopt. However, the disciplinary action voted by the Society shall remain in full force and effect during the pendency of such appeal or appeals.

SECTION 5. The House of Delegates shall have authority to revoke the charter of any district society whose actions are in conflict with the letter or spirit of these Rules and By-Laws.

SECTION 6. *Delegates and Councilors.* — Each component society is entitled to elect one delegate to the House of Delegates of this Society for each twenty active members, or major fraction thereof, of the component society. Regardless of the total number of active members, each component society is entitled to elect at least one delegate. Only Fellows of this Society are eligible for election as delegates. The delegates shall be selected by the component societies at their respective annual meetings, for one year terms, which run from the meeting at which they were elected to the next ensuing annual meeting of the component society. Each component society is entitled to elect one Councilor and one alternate Councilor who shall be Fellows of the Society, and who shall serve two year terms beginning at the close of the annual meeting at which they are elected.

SECTION 7. *Vacancies in Offices.* — If a delegate or councilor elected by a component society dies, resigns, ceases to be a member in good standing of the Society, becomes disabled, or for any other reason cannot assume the duties of his office, or will be absent from a session of the House of Delegates of this Society, the president of the component society may appoint another Fellow to serve in his stead during the balance of the term or during the disability or absence, as circumstances may call for. As soon as practicable after the appointment, the president of the component society shall notify the Secretary of this Society of his action.

SECTION 8. *Secretaries' Duties.* — The secretary of each component society shall keep a roster of its members, grouping the members according to the type of membership held. With respect to each member, the roster shall contain the full name, address, date of birth, professional college and date of graduation, the date the member was licensed to practice in this State, and such other information as the Secretary of this Society may require. The secretary shall also keep a list of licensed physicians

continued on page 480

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BY-LAWS

continued from page 478

practicing within the jurisdiction of the society who are not members. In keeping such records the secretary shall note any change in the personnel of the profession by death or by removal and shall so notify the Secretary in such form as he may require. He shall promptly notify the Secretary of losses of memberships, giving the causes in individual cases.

SECTION 9. *Membership in Society of County Other Than That of Residence.* — Any doctor of medicine living on or near a county line may be elected to membership in that component society whose meetings will be most convenient for him to attend, if the action is agreeable to the component society embracing the county in which the physician resides.

SECTION 10. *Membership Where Major Office and Residence Are in Different Counties or Districts.* — Any doctor of medicine, who has his major office or professional practice in one county and resides in another county, has the option of applying for membership in the component society having jurisdiction of either county, if the action is agreeable to both affected component societies.

SECTION 11. *Transfer Cards.* — When a member in good standing in a component society moves to another county or district he shall, on request, be given a transfer card without cost. He must assume such financial obligations as shall be deemed proper by the component society to which he is transferred, and to which he makes application for membership by transfer.

ARTICLE V — OFFICERS

SECTION 1. *Officers Listed.* — The officers of this Society are the President, President-Elect, Vice President, Secretary, Treasurer, Assistant Treasurer, and the elected Councillors.

SECTION 2. *Tenure of Officers.* — The House of Delegates at its regular annual session in April shall elect the following officers to serve one year terms: President-Elect, Vice President, Secretary, Treasurer, and Assistant Treasurer. Each component society shall be entitled to elect one Councillor and one alternate Councillor to the Council who beginning at the close of the annual meeting of the component society at which they are elected shall assume office and serve until the corresponding period of the second annual meeting following their election or until their successors assume office. The officers elected by the House of Delegates shall assume office at the close of the last general meeting of the annual session at which they were elected and shall serve until the corresponding period of the annual session next following their election. At the close of the last general

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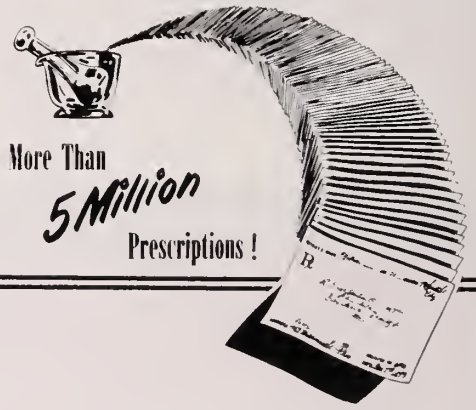
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meeting at the annual session next following his election, the President-Elect shall assume the office of President, and serve as such until the corresponding period of the following annual session or until his successor assumes office.

SECTION 3. *Vacancies; How Filled.* — If before the expiration of the term for which he was elected the President or the President-Elect dies, resigns, is removed, or becomes disqualified, the Vice President shall succeed to the office vacated, with all the prerogatives and duties pertaining to the office as though he had been elected President-Elect in the first instance. Vacancies created by the death, resignation or removal of other officers and vacancies and contingencies not here provided for shall be filled by appointment by the Council for the unexpired portion of the term, except in the case of vacancy in the office of an elected Councillor, the president of the component society concerned shall appoint a person to serve the unexpired portion of the term.

SECTION 4. *Qualifications.* — Only a Fellow of this Society is eligible for election or appointment as an officer.

SECTION 5. *Duties—in General.* — In addition to the rights and duties provided elsewhere in these Rules and By-Laws or as custom or parliamentary usage may require, the officers shall have the rights and duties respectively assigned to them in the succeeding sections of this article.

SECTION 6. *President.* — The following rights and duties devolve on the President: (1) to preside at all general meetings of the Society, of the Council and of the House of Delegates; (2) to deliver an address at the annual session at such time as may be arranged; (3) to act as the real head of the profession in the State and, when he deems it advisable or necessary, to visit personally, or by a representative of his own designation, the various component societies and to assist the Councillors in building up the component societies and in making their work more practical and useful; (4) to serve as a member of the Board of Trustees of the Rhode Island Medical Society Building and to appoint annually in September a Fellow of this Society as a member of the Board of Trustees to serve for a one year term beginning the following January 1; (5) to appoint annually in January to serve for a one year term delegates to other medical societies and an Anniversary Chairman to preside at the next annual dinner; (6) to appoint all committees not otherwise provided for; and (7) ex officio to serve as a member of all committees.

SECTION 7. *Vice President.* — The Vice President shall assist the President in the discharge of his duties and shall officiate for the President

continued on next page

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during his absence or at his request. Ex officio he shall serve as a member of the Council and of the House of Delegates and as Chairman of the Board of Trustees of the Library Building.

SECTION 8. *President-Elect.* — The President-Elect shall by active aid to the President and by membership on the Council and in the House of Delegates of which he is a member ex officio during the term of his office so conduct himself as to obtain the greatest possible acquaintanceship with the affairs and personnel of the Society so as to enable him efficiently to fulfill the office of President when he succeeds thereto.

SECTION 9. *Secretary.* — The following rights and duties devolve on the Secretary: (1) to keep minutes in separate record books of the proceedings of the general meetings of the Society, of the meetings of the Council and of the meetings of the House of Delegates; (2) to be the custodian of the Society's seal; (3) to notify members of meetings, officers of their elections, committees of their appointments and duties, and to send all notices required by these Rules and By-Laws or by order of the House of Delegates or the Council, or by law; (4) to provide for the registration of members and delegates at sessions of the Society and of the House of Delegates and to keep a record of such registration; (5) to keep a register of all component societies, their respective officers, and of all Fellows of the Society and to transmit a copy of this list to the American Medical Association, notifying the Secretary of the American Medical Association monthly as to the names of new Fellows and the names of those dropped from the Fellowship roster during the preceding month; (6) to keep a card index and register of all licensed practitioners of the state by county, noting the status of each in relation to the appropriate component society; (7) to be the custodian of all record books and papers of the Society except such as properly belong to the Treasurer; (8) to see that each Fellow is supplied with a copy of every essay published by the trustees of the Fiske or other funds; (9) to report annually to the House of Delegates; (10) to prepare and issue all programs as may be directed by the Committee on Scientific Work and annual meeting; (11) to aid the Council in the organization and improvement of the district societies and in the extension of power and usefulness of this Society; (12) to perform such other duties as may be required by the Council or the House of Delegates; (13) to be *ex officio* a member of all Standing Committees. The Secretary shall be exempt from the payment of annual dues.

SECTION 10. *Treasurer.*—The following rights and duties devolve on the Treasurer: (1) to serve ex officio as a member of the Council, of the House of Delegates, of the Board of Trustees of the Rhode Island Medical Society Building, and of the Committee on Scientific work and Annual meeting; (2) to charge on the books of the Society the dues of each Fellow and to demand and receive all funds due the Society, including bequests and donations, to deposit same in a depository approved by the Council, and to keep an accurate record thereof as well as of funds disbursed by the Society; (3) at the Council meeting in September to present to the Council, for its approval, a budget of necessary expenses of the Society for the ensuing year and to pay all bills within the scope of the approved budget; (4) to pay only on the order of the Council bills not within the scope of the approved budget; (5) under the supervision of the Council to invest the funds under his care; (6) after receiving the recommendation of the Council, to sell, mortgage, or lease any property belonging to the Society and to execute the necessary legal documents therefor; (7) when directed by the House of Delegates, to sue in the name of the Society and to prosecute such suits to final judgment and execution; (8) to subject his accounts to examination by the auditors annually; (9) to render an account of his work and of the state of the funds in his hands at the April meeting and to make in writing such other reports as the House of Delegates or the Council may require; (10) to employ such assistants as may be authorized by the Council; and (11) to give bond in such sum as may be fixed by the Council, the premium on such bond to be paid by the Society.

SECTION 11. *Assistant Treasurer.* — In accordance with the Treasurer's direction or request, the Assistant Treasurer shall assist him in the performance of his duties.

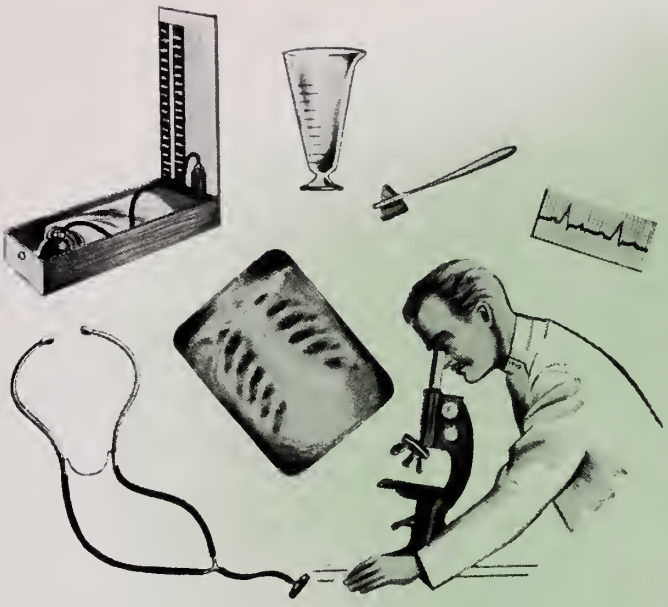
ARTICLE VI — HOUSE OF DELEGATES

SECTION 1. *General Powers.* — All legislative power of the Society, is vested in and resides in the House of Delegates, which alone shall have authority to determine the policies of the Society. It shall elect (1) all the officers, (2) such delegates to the American Medical Association to which the Society may be entitled, and (3) the elected committeemen.

SECTION 2. *Composition.* — The House of Delegates shall be composed of (1) delegates elected by the component societies, each component society being entitled to elect one delegate for each twenty active members in good standing, or major fraction thereof, provided each component society shall be entitled to elect at least one delegate; and (2) the President, the President-Elect, the Vice President, the Secretary and the Treasurer.

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1. Lapin, J. H.; Goldman, S. F., and Goldman, A.: New York State J. Med. *43*:1964, 1943.

*T.M

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BY-LAWS

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SECTION 3. *Conduct of Business.* — The House of Delegates in its deliberations shall be presided over by the President and in his absence by the Vice President and in his absence by the President-Elect and in his absence also by any delegate agreeable to it. Eleven delegates shall constitute a quorum for the transaction of business. The Secretary shall record the proceedings.

SECTION 4. *Time of Meeting.* — The House of Delegates shall meet in January, April, and September at such place and time as the Council may determine. The House may be called into special session at any time during the year by the President in his discretion or on the written petition of ten delegates or twenty-five Fellows.

SECTION 5. *Special Committees.* — The House of Delegates may appoint committees composed of any Fellows of the Society for special purposes or it may provide for such committees and authorize the appointment of Fellows by the President. Such committees shall report to the House of Delegates and members of such committees may participate in discussion and debate relative to their reports but unless committeemen are delegates they shall not have the right to vote.

SECTION 6. *Reporting of Proceedings.* — When the House of Delegates meets the Secretary shall cause a summary of the proceedings to appear as soon as practicable in the Society's official publication.

SECTION 7. *Election of Officers, Delegates to the American Medical Association, and Elected Committeemen.* — At its meeting in September on the even year the House shall elect a delegate and alternate to the House of Delegates of the American Medical Association, and annually at its meeting in April shall elect officers and elected committeemen. With respect to both elections, the Council shall appoint from its membership a nominating committee of five which shall prepare a list of candidates to be presented to the Council. A list of nominees approved by the Council shall be mailed to the members of the House two weeks prior to the meeting. Other nominations may be made from the floor of the House by any member of the House. All elections shall be by ballot and a majority of the votes cast shall be necessary to elect.

SECTION 8. *Memorials and Resolutions.* — No memorial or resolution can validly be issued in the name of the Society unless adopted by the House of Delegates.

SECTION 9. *Reports of Officers.* — All officers, the Council, and the chairmen of the standing committees shall prepare and submit for the consideration of the House at its April meeting reports in writing concerning their activities during the past year.

SECTION 10. *Fixing of Annual Dues.* — The House at its September meeting shall determine and fix the dues for the ensuing fiscal year.

ARTICLE VII — THE COUNCIL

SECTION 1. *General Powers.* — The Council shall carry out the mandates and policies of this Society as determined by the House of Delegates or by referendum or initiative measures. Subject only to the provisions of (1) these Rules and By-Laws, (2) resolutions or enactments of the House of Delegates, and (3) measures initiated at the general session, the Council has full and complete power and authority to perform all acts and to transact all business for the Society and to manage and conduct all of the property, affairs, work and activities of the Society.

SECTION 2. *Composition.* — The Council shall consist of the Councillors elected by the component societies, the five most recent living past Presidents of the Society, the President, the President-Elect, the Vice President, the Secretary, the Treasurer, and the Assistant Treasurer.

SECTION 3. *Meetings.* — The Council shall meet bimonthly at such time and place as the President may determine. The President may call a special meeting of the Council on his own motion and must call a special meeting on the written request of three members of the Council. Five members shall constitute a quorum. The President shall preside at meetings of the Council and, in his absence, the Vice President and President-Elect in order. The Secretary shall keep a record of its proceedings.

SECTION 4. *Duties.* — In addition to the duties and powers conferred on the Council elsewhere in these Rules and By-Laws, the Council shall act as the arbiter of the Society with respect to matters of ethics and questions involving the rights and standing of Fellows, whether in relation to other Fellows, to the component societies, or to this Soci-

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[1]Cooke, R. A.: *Allergy in Theory and Practice,* Philadelphia: W. B. Saunders Company, 1947, p. 186

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COUNCIL ACCEPTED

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ety. When its jurisdiction is invoked as hereinafter provided it shall review instances in which disciplinary orders or measures have been adopted by a component society against a member.

SECTION 5. *Appeals and Disciplinary Proceedings.* — A member of a component society censured, suspended, expelled, or otherwise disciplined by his component society may appeal to the Council within two months following the date of such disciplinary order for a determination of applicable questions of law and procedure but not of fact. Appeals shall be in writing and be filed with the Secretary of the Society. On the filing of an appeal the Secretary shall notify other members of the Council. Appeals shall be heard by the Council only after reasonable notice in writing of not less than ten days of the time and place of the hearing on the appeal has been given to the appellant member and the president and secretary of the component society. In every case of an appeal the Council, prior to any hearing on the appeal shall exert all proper efforts at conciliation and compromise. The decision of the Council shall be final and bind the appellant member and the component society unless the matter is carried timely to the Judicial Council of the American Medical Association.



SECTION 6. *Report to the House of Delegates.* — The Council at each session of the House of Delegates shall make a report concerning the state of the Society and the work and proceedings of the Council during the interval since the last session of the House.

SECTION 7. *Compensation of Officers and Employees.* — The Council shall fix the compensation of the officers, representatives and employees of the Society.

SECTION 8. *Executive Secretary.* — The Council may employ an Executive Secretary of the Society after authorization by the House of Delegates.

ARTICLE VIII — SESSIONS AND MEETINGS

SECTION 1. *Sessions of the Society.* — The Society shall hold an annual session at such place and at such time as the House of Delegates may determine. The Secretary shall give to each member at least seven days' notice of such annual session.

SECTION 2. *General Meetings.* — During the annual session there shall be held at least one general meeting open to all registered members and guests. The general meeting may recommend to the House of Delegates the appointment of committees or commissions for scientific investigations of special interest and importance to the profession and to the public. The general meeting by a two-thirds vote of the Fellows present may order a general referendum on any question pending before the House of Delegates and when so ordered the House of Delegates shall submit such question to the Fellows of the Society by ballot sent by mail. A majority of such votes shall determine the question and be binding on the House of Delegates. The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum in the above-specified manner, and it shall be bound by the results. The general meeting may receive and vote on resolutions introduced at any session but the resolutions shall not be binding on the Society until approved by the House of Delegates.

SECTION 3. *Special Sessions.* — A special session of the Society may be called by the President in his discretion and must be called by him on the written petition of twenty-five Fellows.

SECTION 4. *Right of Members to Participate In.* — All members of the Society may attend and, except as otherwise limited, may participate in the annual session held by the Society, subject only to such reasonable parliamentary rules as may be adopted. Members may also attend meetings of the House of Delegates, except when the House of Delegates is in executive session. Except with

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BY-LAWS

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the consent of the House of Delegates, however, no member not a delegate may have the privilege of the floor.

SECTION 5. *Registration Required.* — Before a member can attend and participate in proceedings or activities of the annual sessions he must register, under such procedure as the Secretary may prescribe.

SECTION 6. *Guests.* — The privilege of attending the annual session may be extended to guests under such conditions as the Secretary may determine.

SECTION 7. *Length of Papers or Addresses.*— No address or paper read before a general or section meeting, except those of the President and invited guests, shall occupy more than thirty minutes in its delivery. In the discussion following a paper or address at such a meeting no member shall be permitted to speak longer than five minutes on any subject without general consent.

SECTION 8. *Property and Papers.*—The authors of all papers and addresses presented before this Society shall be requested to deposit them with the Secretary for publication in the official Journal of the Society.

ARTICLE IX — FINANCE

SECTION 1. *Raising of Funds.*—Funds for conducting the affairs of the Society may be raised (1) by such annual dues from Fellows of this Society as the House of Delegates may determine at its September meeting; (2) by such special assessments on members as the House of Delegates may determine; (3) by voluntary contributions, devises, bequests, and other gifts; and (4) in any other manner approved by the House of Delegates.

SECTION 2. *Fiscal Year.* — The fiscal year of this Society is from January 1 to December 31 inclusive.

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SECTION 3. *Supervision.* — Supervision of the funds, investments, and expenditures of the Society is vested in the Council. The Council shall receive the audited accounts of the Treasurer and of other agents of the Society and present a statement of those accounts in its annual report to the House of Delegates. It shall pass on the sufficiency of the bond given by the Treasurer. It shall report on all resolutions appropriating money and shall submit such report to the House of Delegates for authorization or approval. At the meeting of the House of Delegates in September the Council shall submit a budget for the expected income and expenses of the Society for the ensuing year. If it approves the House of Delegates shall make the necessary appropriations and impose such conditions on the expenditure of the funds so appropriated as it sees fit, provided, in the case of an emergency the Council may authorize the expenditure of funds for items not mentioned in the budget for that year.

ARTICLE X

STANDING COMMITTEES AND BOARDS OF TRUSTEES

SECTION 1. *Names.* — The standing committees of the Society shall be the following: Committee on Scientific Work and Annual Meeting, Committee on Public Laws, Committee on Publication, Committee on Postgraduate Education, Committee on Medical Economics, Committee on Industrial Health, Committee on the Library, Committee on Public Relations and Policy, Trustees of the Rhode Island Medical Society Building, Trustees of the Caleb Fiske Fund, Trustees of the Special Funds, Auditors.

SECTION 2. *Required Reports.* — Each of these committees shall at the April meeting of the House of Delegates report in writing concerning its activities during the past year. The Trustees of the Caleb Fiske Fund and the Trustees of the Special Funds shall report to the Council.

SECTION 3. *Vacancies.* — If an elected committeeman dies, resigns, is removed or fails to serve, the Council shall appoint some Fellow of the Society to serve until the next session of the House of Delegates at which time the House shall elect some Fellow of the Society to serve for the unexpired portion of the term.

SECTION 4. *Scientific Work and Annual Meeting.* — The Committee on Scientific work and Annual meeting shall consist of the President, the Secretary, and the Treasurer, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall determine the character and scope of the scientific proceedings of the Society for each session, subject to instruction of the House of Delegates. It shall be the duty of the Committee

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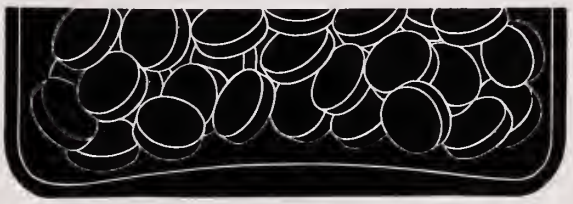
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THE CARE OF HAND INJURIES

The 5th of a series of articles prepared by the American Society for Surgery of the Hand, and distributed by the Committee on Trauma, American College of Surgeons

V

FRACTURES AND DISLOCATIONS

I *Protection of the Hand* (Abstract of Article I)

The first-aid care of wounds of the hand is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. The best first-aid management consists in the application of a sterile protective dressing, a firm compression bandage and immobilization by splinting in the position of function.* No attempt should be made to examine, cleanse or treat the wound until operating room facilities are available.

II *Requirements of Early Definitive Treatment* (Abstract of Article II)

Early definitive care requires thorough evaluation of the injury with respect to its cause, time of occurrence, status as regards infection, nature of first-aid treatment and appraisal of structural damage. For undertaking definitive treatment, the conditions required are a well-equipped operating room, good lighting, adequate instruments, sufficient assistance, complete anesthesia and a bloodless field. Treatment itself consists of aseptic cleansing of the wound, removal of devitalized tissue and foreign material (exercising strict conservation of all viable tissue), complete hemostasis, the repair of injured structures, protecting nerves, bones and tendons and providing maximum skin coverage and the application of firm protective dressing to maintain the optimum position. After-treatment consists of protection, rest and elevation during healing, and early restoration of function by directed active motion.

III *Surface Injuries* (Previously circulated)

IV *Lacerated Wounds* (Previously circulated)

V *Fractures and Dislocations*

The purposes of treatment of closed fractures and dislocations of the bones of the hand are:

1. Protection of the injured bony structures from further displacement and avoidance of added damage to soft parts.
2. Restoration of normal relations of the bony structures.
3. Maintenance of the corrected relation of the bones to permit healing, at the same time avoiding stiffening in position of nonfunction.
4. Restoration of function.

These objectives are sought in the various stages of treatment.

1. First-aid treatment
   a. Avoid manipulation or attempts at reduction until skilled attention is available and accurate diagnosis has been made.
   b. Prompt protection of the hand by complete immobilization in the position of function pending definitive treatment.
2. Definitive treatment.

When proper skill and facilities are available, this consists of:

a. Diagnosis by means of
   1—Inspection to determine swelling, ecchymosis, deformity, loss of function.
   2—Palpation, gently employed, to discover bony irregularity, point of maximum tenderness, referred pain. This sign is of importance in discovering fractures of the long bones, particularly where deformity may not exist or is concealed by swelling. Gentle pressure in the line of axis of the long bone will result in pain at the fracture site.
   3—X-ray examination. Obligatory where fracture or dislocation is suspected. Injuries in the region of the carpus require not only antero-posterior and lateral views but two or more oblique views in addition. Fractures of the carpal bones frequently fail to show in antero-posterior and lateral views.

b. Reduction. Restoration of normal position of bony structures should be secured at the earliest possible time by:
   1—Manipulation.

   Whether reducing a fracture or a dislocation, full relaxation, preferably

continued on page 492

*Position of function or position of grasp: wrist hyperextended in cock-up position; fingers in mid-flexion and separated; thumb abducted, slightly forward from hand and slightly flexed.

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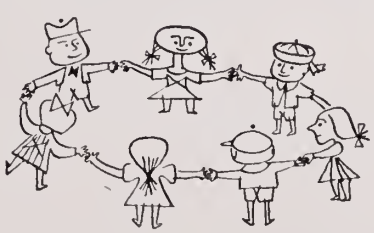
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CARE OF HAND INJURIES

continued from page 490

under general anesthesia, is desirable. Manual traction, pressure and moulding should be gentle and deliberate to avoid further soft-part injury.

When attempts at reduction by manipulation are not promptly successful under these conditions, they should be abandoned in favor of open (operative) replacement. Dislocation at the metacarpophalangeal joint of the thumb will almost invariably require open reduction.

2—Skeletal control.

To maintain reduction, particularly of oblique or comminuted fractures of phalanges or metacarpals or fractures into joints, control by skeletal fixation may be required. This may be applied by means of a length of thin Kirschner wire inserted transversely through the distal end of the fractured bone or through the terminal phalanx of the finger. The hand and injured finger or fingers should be supported in the position of function on a palmar moulded curved form or ball splint. This alone will ordinarily suffice to maintain proper position after reduction by manipulation. When control by skeletal fixation is required for maintenance of reduction, the transfixing wire may be connected to this splint on its palmar aspect or to a projecting frame, at or above wrist level, by elastic bands. Fixation or traction by means of a hole in the finger nail, or by adhesive applied to the finger, or by woven constricting device is not satisfactory. Continued straight traction on the fingers in the extended position is to be avoided.

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3—Open reduction.

When manipulation fails to produce satisfactory reduction, open operative reduction is to be employed. This requires careful preliminary skin preparation and should be carried out under optimum operating conditions as described in II (Requirements of Early Definitive Treatment).

3. Maintenance of reduction.

Immobilization of bony injury following reduction should:

(a) Be secured with firm, even pressure bandaging, permitting no motion at site of injury.

(b) Be nonconstricting, not interfering with circulation.

(c) Be comfortable, causing no excess pressure.

(d) Preserve, as far as possible, the position of function, taking into account the normal concavities of the palmar surface of the skeletal structure (arches of the hand) and flexor surface curves of the phalanges. (Wrist in 30° dorsiflexion, metacarpophalangeal and distal interphalangeal joints in 45° flexion and middle interphalangeal joint in 90° flexion.) Flat splinting is to be condemned.

(e) Leave free to move all joints whose motion will not jeopardize position and healing. During immobilization, active motion of all joints not necessarily confined is to be encouraged.

Immobilization may be accomplished by:

(1) Splinting or plaster casting, applied as described in 2 B Reduction.

(2) Internal fixation. Kirschner wires may be employed, following either open or closed reduction, as axial intramedullary splints for individual long bones (not to protrude into a joint); as transversely introduced fixation pins passing through adjacent bones to secure the fragments of metacarpal fractures; as penetrating fixation for fragments of carpal fractures.

Wiring or plating of fractures of the bones of the hand is generally unsatisfactory.

During the early period of immobilization, elevation of the hand is desirable. Immobilization of the injury should be consistent and continuous until healing and firm union have been established.

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CARE OF HAND INJURIES

concluded from page 492

Healing of ligamentous injuries accompanying dislocations requires two weeks of immobilization following reduction.

Healing of fractures of the long bones requires immobilization for three to five weeks.

Healing of carpal bone fractures requires twelve to fourteen weeks' immobilization. Fractures of the navicular may require four months to unite. If immobilized consistently for this length of time, most of these fractures will not require surgical intervention.

4. Restoration of function.

During the healing process, all joints not necessarily immobilized should be freely moved to activate their controlling muscles and their use by the patient encouraged.

Following establishment of healing or firm union, restoration of function is secured by directed active motion, particularly through the means of exercise and occupational therapy.

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SYMPATHETIC NERVE BLOCK

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[7] Livingston, W. K.: Pain Mechanism. McMillan, 1944.

[8] Homans, J.: Minor Causalgia. N.E.J.M. 222, 1940.

[9] Evans, J.: Reflex Sympathetic Dystrophy. Ann. Int. Med., 1947.

[10] Judovich & Bates: Segmental Neuralgia. F. A. Davis Co., 1946.

[11] De Takats, G.: Causalgic States. J.A.M.A. 128, 1945.

[12] Oschner & De Bakey: Sym. Block in Postphlebitic Edema. J.A.M.A., Feb. 1949.

[13] Shumacker, Upjohn, Speigel: Sympathetic Interruption in Causalgia. Surg. Gyn. Obs. 86, 1948.

[14] Reynolds & Jirka: Treatment of Arterial Occlusion. Surg. 16, 1944.

[15] Console, A.: Segmental Arterial Spasm (following Supra-condylar Fracture of Elbow). Surg. Clinics North America, Nov. 1948.

BY-LAWS

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to provide a suitable place and to make all necessary arrangements for each meeting of the Society. The Committee shall prepare and issue at least seven days previous to each session a program announcing the order in which papers, discussions, and other business shall be presented.

SECTION 5. *Public Laws.* — The Committee on Public Laws consists of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall keep itself informed with respect to laws, court decisions, court proceedings, administrative rules, and proposed and pending legislation relating to public health and such other matters as relate to the objects of the Society.

SECTION 6. *Publication.* — The Committee on Publication consists of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall arrange for the publication and distribution and have charge of all the Society's publications. Expenses of the Committee must be authorized by the Council, and subsequently reported to the House of Delegates. All receipts shall accrue to the Treasurer.

SECTION 7. *Postgraduate Education.* — The Committee on Postgraduate Education shall consist of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall act in conjunction with the Council to provide postgraduate clinics, courses and other instruction for the component societies and the Fellows of this Society.

SECTION 8. *Medical Economics.* — The Committee on Medical Economics consists of the President and the Secretary ex officio and nine (9) members elected by the House of Delegates. The committee shall be charged with the duty of studying and investigating, so far as it and the Council may deem practicable or advisable, such phases of general economics as have a bearing on the practice of medicine.

SECTION 9. *Industrial Health.* — The Committee on Industrial Health shall consist of the President and the Secretary ex officio and nine (9) members elected by the House of Delegates. The Committee on Industrial Health shall keep itself informed concerning: (1) actual conditions and practices in industry affecting or relevant to the health and well-being of industrial workers; (2) the medical care rendered as a result of industrial accidents or occupational diseases; and (3) legislation pertinent to the field of industrial health.

This committee shall also study, determine, and advocate such measures, and laws as in its judgment will improve the welfare of the industrial worker. Such a committee shall cooperate with other agencies having a legitimate interest in the health of industrial workers. It shall coordinate its activities, so far as possible, with the activities of the Council on Industrial Health of the American Medical Association.

SECTION 10. *Library.* — The Committee on the Library consists of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall have charge of the Library of the Society and shall have custody of all books and pamphlets published by the Society and the Trustees of the Fiske Fund. It shall appoint some suitable person Librarian, the amount of whose compensation shall be approved by the Council, shall make rules concerning the use of the Library. The Librarian shall keep a list of all additions to the Library, shall see that the Library is open for reference at such hours as the Committee may direct, shall compile the necessary catalogs and reference lists, shall loan books from the Library only on receipts, and shall perform such other duties as may be assigned by the Committee.

SECTION 11. *Public Policy and Relations.* — The Committee on Public Policy and Relations shall consist of the President and the Secretary, ex officio, and nine (9) members elected by the House of Delegates. The Committee shall concern itself with all matters of public policy, public relations, education and information relative to medicine and public health.

SECTION 12. *Rhode Island Medical Society Building.* — The Board of Trustees of the Rhode Island Medical Society Building consists of seven members as follows: the Vice President, who shall be chairman, the chairman of the Library Committee, one person elected by the Providence District Society, one person not a member of the Providence Society, who shall be appointed by the President, the President, the Secretary, and the Treasurer. The Committee shall have charge of the Library building, shall appoint some suitable person janitor, assign him his duties and fix his compensation, but the amount must be approved by the Council. Through the budget of the Treasurer this Committee shall recommend to the Council the amount necessary for the maintenance of the building. Other expenses of the Committee must be authorized by the Council, which expenditures must subsequently be reported to the House of Delegates.

SECTION 13. *Auditors.* — The House of Delegates shall at its April meeting elect an Auditor to serve a two-year term. A member to be eligible for election or appointment as an Auditor must not have served in such capacity for the Society within the preceding year. The Auditors shall annually make careful examination of the Treasurer's books and vouchers and make a report of their findings to the Council.

SECTION 14. *Caleb Fiske Fund.* — The President, the President-Elect, and the Vice President shall be the Trustees of the Caleb Fiske Fund.

SECTION 15. *Other Special Funds.* — The President, the Secretary and the Treasurer shall be the Trustees of such special funds as have been created and may be created hereafter, provided other Trustees are not designated by the creators of the funds or appointed by the House of Delegates.

ARTICLE XI
DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

SECTION 1. *Selection and Terms.* — The House of Delegates at its September meeting on the even year shall elect a delegate and alternate to the House of Delegates of the American Medical Association, in conformity with the applicable provisions of the Constitution and By-Laws of the American Medical Association.

SECTION 2. *Assumption of Office.* — The Delegate and alternate shall assume office on January 1 of the year succeeding their election, for two year terms, and shall serve until their successors are elected and assume office.

SECTION 3. *Vacancy During Elected Terms; How Filled.* — If before the termination of his term the delegate dies, resigns, ceases to be a member in good standing of this Society, becomes disabled or for any other reason cannot assume or continue to assume the duties of his office or will be absent from a session or meeting of the House of Delegates of the American Medical Association, the rights and duties of the office devolve on his alternate for the time being or for the remainder of the term as circumstances, in the opinion of the Council, may indicate.

ARTICLE XII — ETHICS

The Code of Ethics of the American Medical Association in force at the time of the adoption of these Rules and By-Laws and as it may from time to time thereafter be amended by the American Medical Association shall govern the conduct of members of this Society in their relation to each other and to the public.

ARTICLE XIII — OFFICIAL PUBLICATION

The official publication of this Society is the Rhode Island Medical Journal, in which shall be published all official Society notices and transactions of the House of Delegates, the general meetings of the Society, and abstracts of the meetings of the Council.

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PRINCIPLES OF MEDICAL ETHICS

The recently revised Code of Ethics of the American Medical Association is being reprinted for the general information of the membership.—[Ed.]

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803).

Chapter I

General Principles

Character of the Physician

Section 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

The Physician's Responsibility

Sec. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

* Sir Thomas Watson.

Groups and Clinics

Sec. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

Advertising

Sec. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or instituion has been, or is, concerned. Self-laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

Educational Information Not Advertising

Sec. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of

cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

Patents, Commissions, Rebates and Secret Remedies

Sec. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

Evasion of Legal Restrictions

Sec. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

Chapter II

Duties of Physicians to Their Patients

Standards, Usefulness, Nonsectarianism

Section 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

* Nicon, Father of Galen.

Patience, Delicacy and Secrecy

Sec. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

Prognosis

Sec. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

The Patient Must Not Be Neglected

Sec. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

Chapter III

Duties of Physicians to Each Other and to the Professions at Large

Article I — Duties to the Profession

Upholding the Honor of the Profession

Section 1.—A physician is expected to uphold the dignity and honor of his vocation.

Membership in Medical Societies

Sec. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

continued on next page

Safeguarding the Profession

Sec. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

Sec. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be considered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

Article II — Professional Services of Physicians to Each Other

Dependence of Physicians on Each Other

Section 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

Compensation for Expenses

Sec. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

One Physician in Charge

Sec. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

Article III — Duties of Physicians in Consultations

Consultations Should Be Encouraged

Section 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

Consultation for Patient's Benefit

Sec. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

Punctuality

Sec. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful: he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

Patient Referred to Consultant

Sec. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

Discussions in Consultation

Sec. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

Responsibility of Attending Physician

Sec. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However,

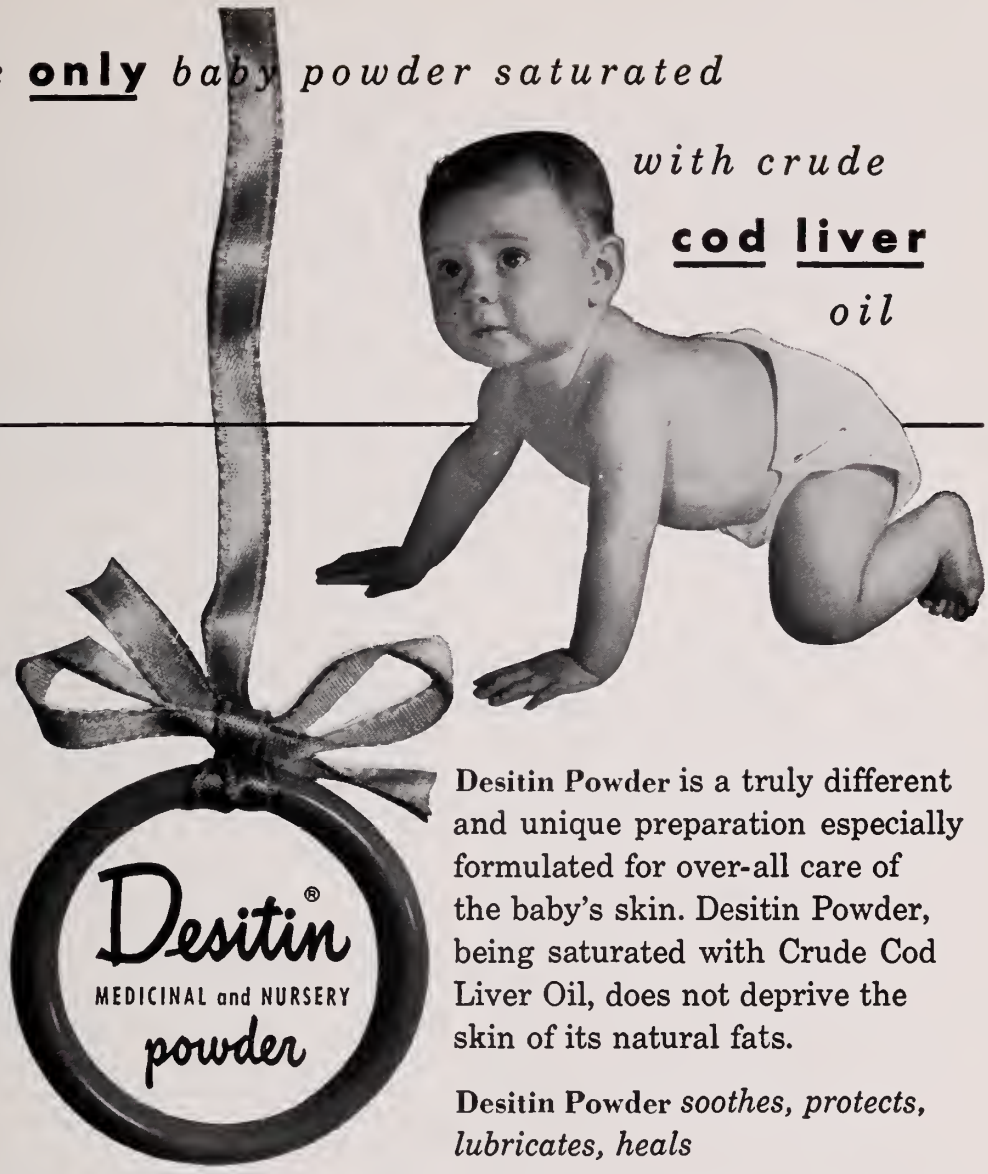
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PRINCIPLES OF MEDICAL ETHICS

concluded from page 498

after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

Conflict of Opinion

SEC. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

Consultant In Attendance

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV — DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

Misunderstandings to be Avoided

SECTION 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

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Social Calls on Patient of Another Physician

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

Services to Patient of Another Physician

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

Criticism to be Avoided

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

Emergency Cases

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

Precedence When Several Physicians Are Summoned

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish someone other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A Colleague's Patient

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

Substitution in Obstetric Work

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V — DISPUTES BETWEEN PHYSICIANS

Arbitration

SECTION 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI — COMPENSATION

Limits of Gratuitous Service

SECTION 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

Conditions of Medical Practice

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

Contract Practice

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

Free Choice of Physician

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

Commissions

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

Purveyal of Medical Service

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

Chapter IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

Physicians as Citizens

SECTION 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

Public Health

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk of his own health.

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

Conclusion

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

BY-LAWS

concluded from page 495

ARTICLE XIV — RULES OF ORDER

In the absence of any provision in these Rules and By-Laws to the contrary, all general meetings of the Society and all meetings of the House of Delegates, of the Council, and of Committees shall be governed by the parliamentary rules and usages contained in the then current edition of Robert's "Rules of Order."

ARTICLE XV — AMENDMENTS

These Rules and By-Laws may be amended in any general meeting of the Society by a majority vote of the Fellows present and voting, provided the proposed amendment has been presented to the House of Delegates and has received its approval.

ARTICLE XVI

REPEAL OF PREVIOUS RULES AND BY-LAWS AND MOTIONS

On the adoption of these Rules and By-Laws (1) all previous Rules and By-Laws and (2) motions of record and rules and regulations in conflict with these Rules and By-Laws are hereby repealed, provided that all officers, delegates, and elected committeemen now in office shall continue their incumbency until their successors are duly elected as provided in these Rules and By-Laws.

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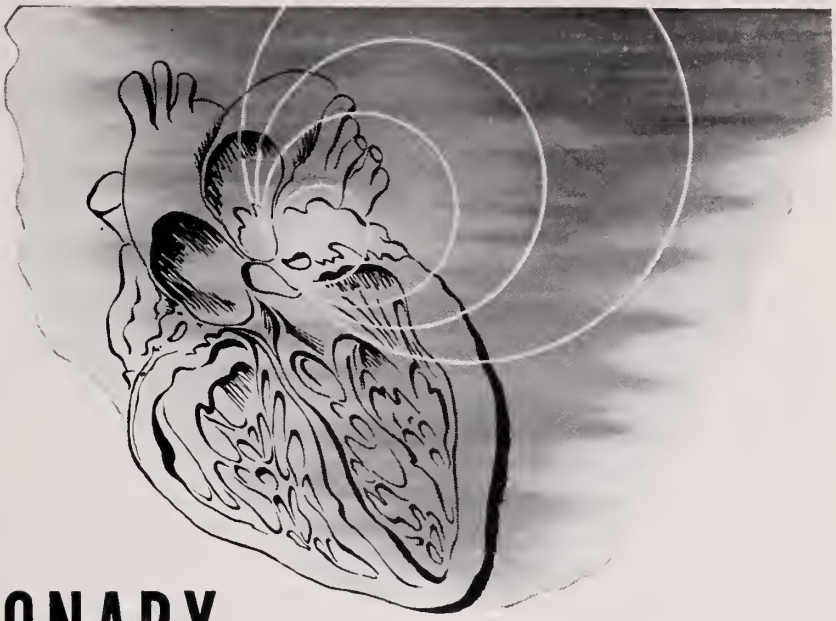
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"THE PREVENTIVE ASPECTS OF HEART DISEASE"

DAVID B. RUTSTEIN, M.D., of Boston, Massachusetts
Professor of Preventive Medicine, Harvard Medical School

MONDAY, SEPTEMBER 25 —

"AN EVALUATION OF METHODS OF TREATMENT OF HYPERTENSION"

GEORGE PERERA, M.D., of New York City
Associate Professor of Medicine, Columbia University; Assistant Attending Physician, Presbyterian Hospital.

MONDAY, OCTOBER 2 — (Joint meeting with Providence Medical Association.)

"TYPES OF CONGENITAL HEART DISEASE AMENABLE TO SURGERY"

ROBERT E. GROSS, M.D.
William E. Ladd Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Children's Medical Center, Boston.

MONDAY OCTOBER 9 —

"EARLY MANIFESTATIONS OF CONGESTIVE HEART FAILURE AND THEIR MANAGEMENT"

C. SIDNEY BURWELL, M.D.
Research Professor of Clinical Medicine, Harvard Medical School; Physician, Peter Bent Brigham Hospital, Boston.

MONDAY, OCTOBER 16 —

"PATHOGENESIS OF ANGINA PECTORIS AND SOME CLINICAL IMPLICATIONS"

HERRMAN L. BLUMGART, M.D.
Professor of Medicine, Harvard Medical School; Physician-in-Chief, Beth-Israel Hospital, Boston

MONDAY, OCTOBER 30 —

"RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE"

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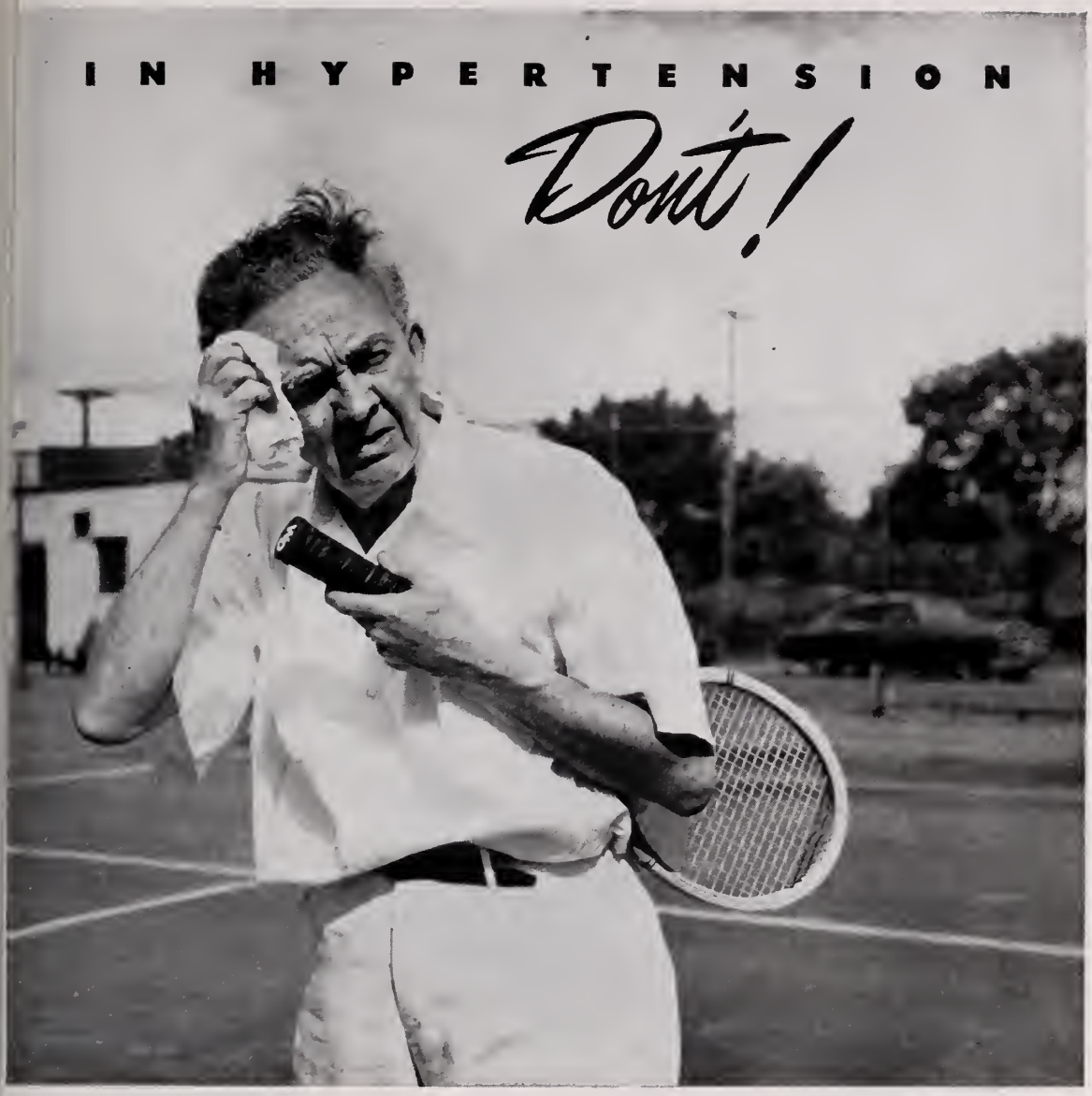
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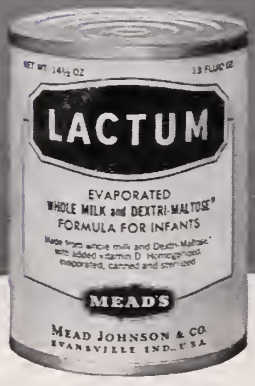
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(See Page 510)

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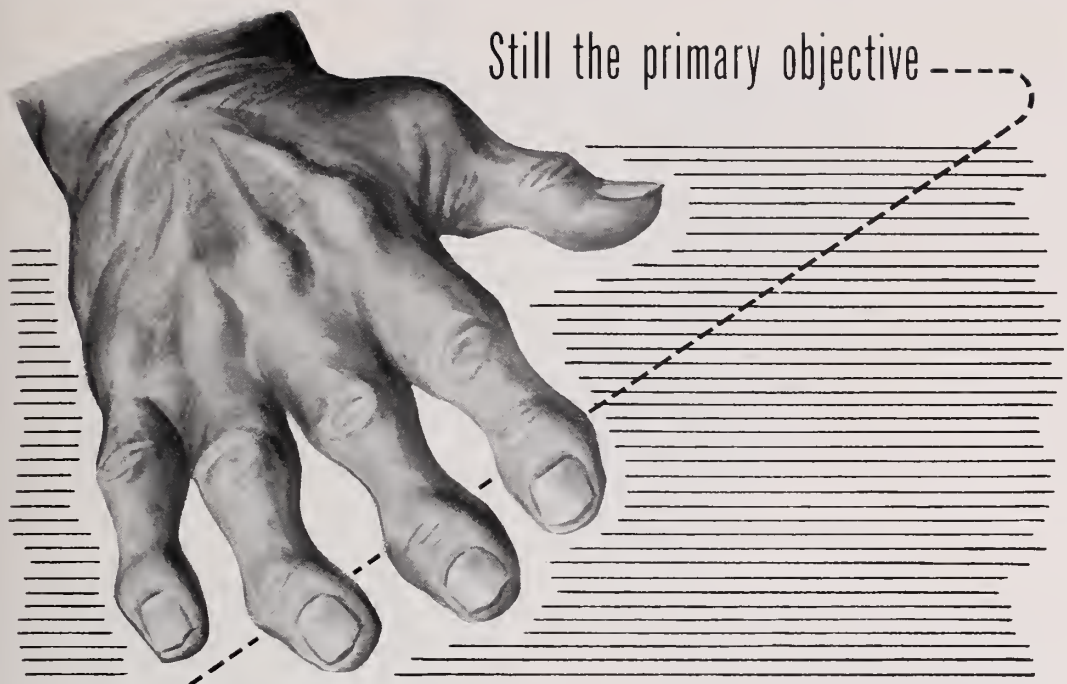
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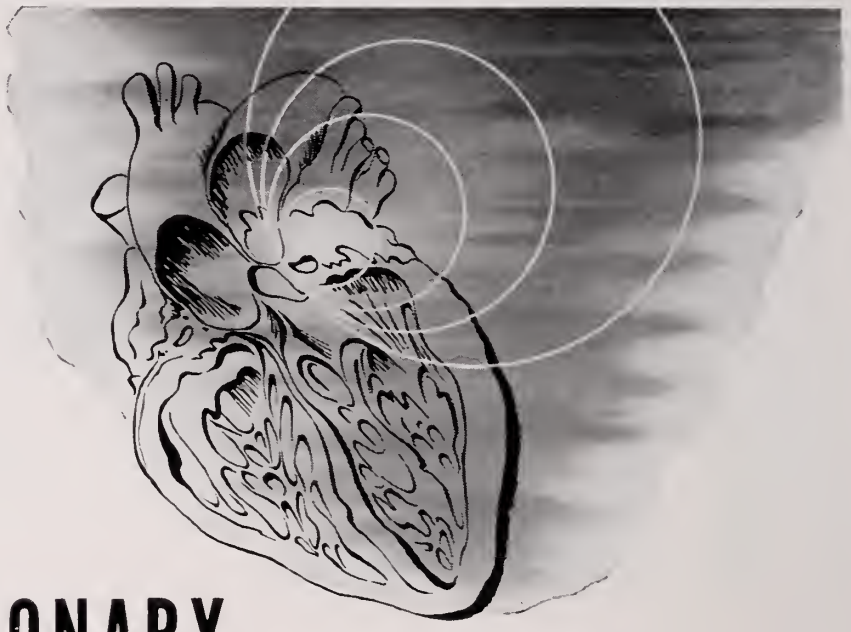
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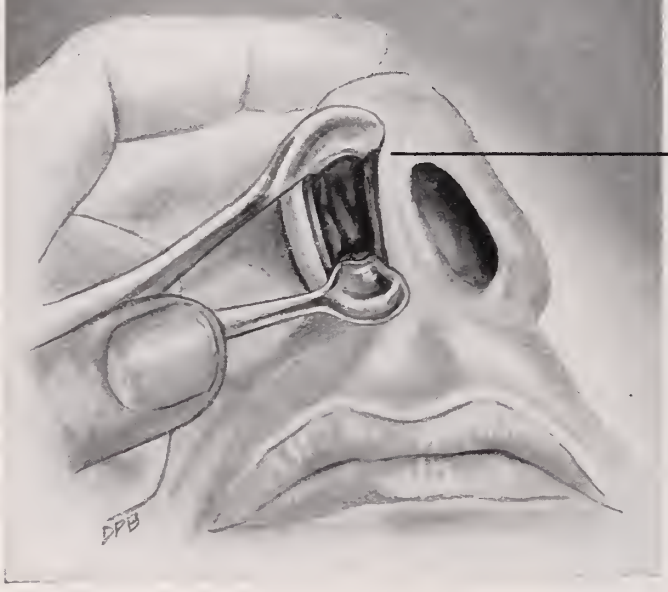
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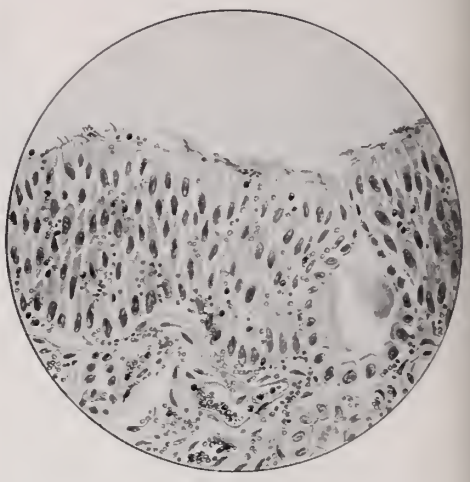
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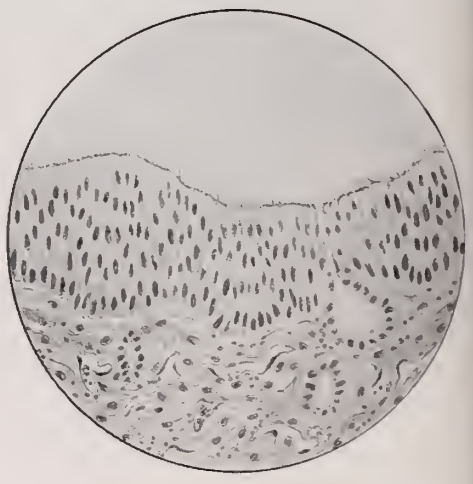
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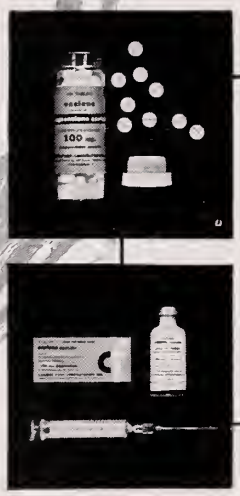
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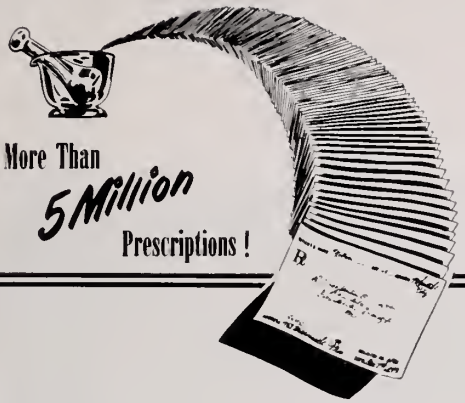
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1. King, E. Q.; Lewis, C. N.; Welch, H.; Clark, E. A., Jr.; Johnson, J. B.; Lyons, J. B.; Scott, R.B., and Cornely, P. B.: J. A. M. A. 143:1 (May 6) 1950.
2. Herrell, W. E.; Heilman, F. E.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950
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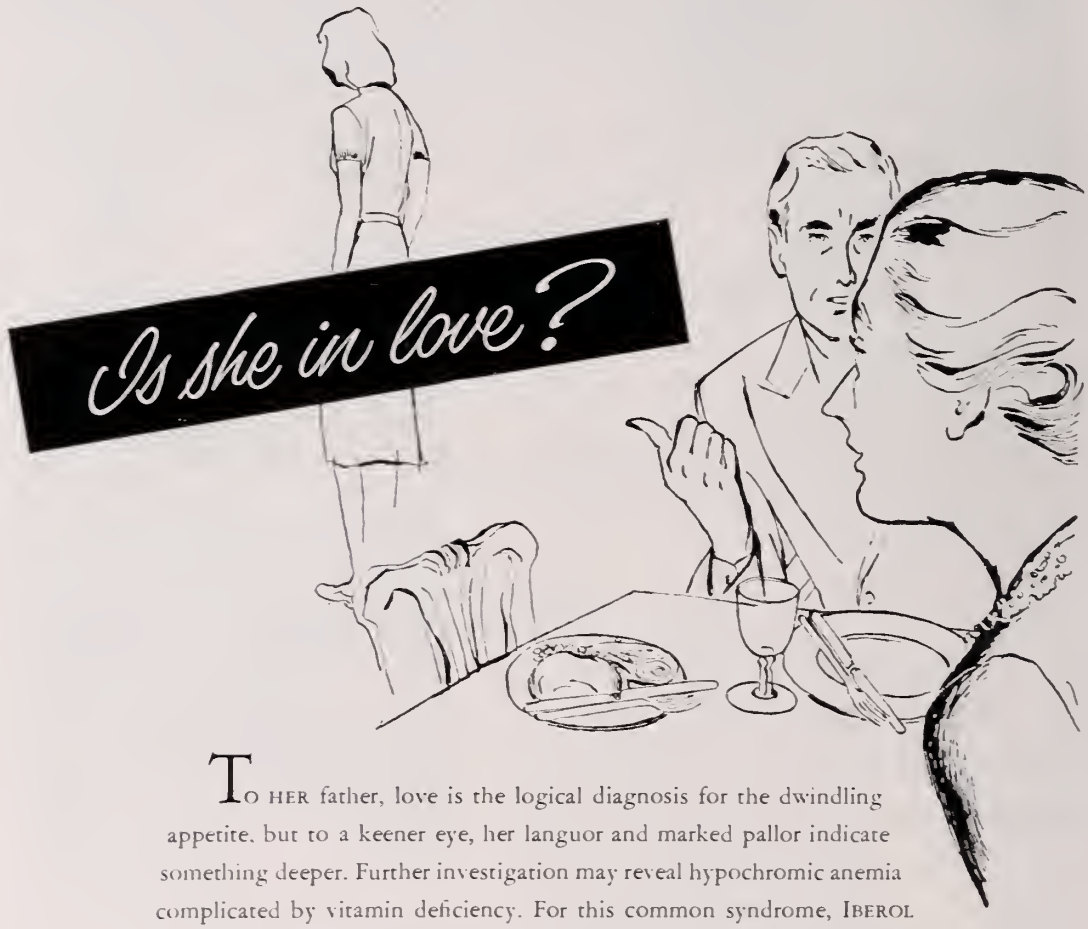


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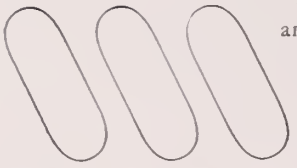
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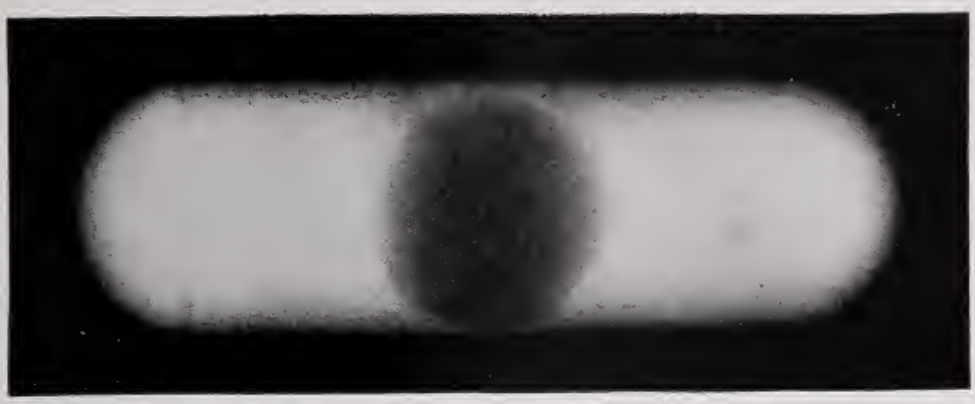
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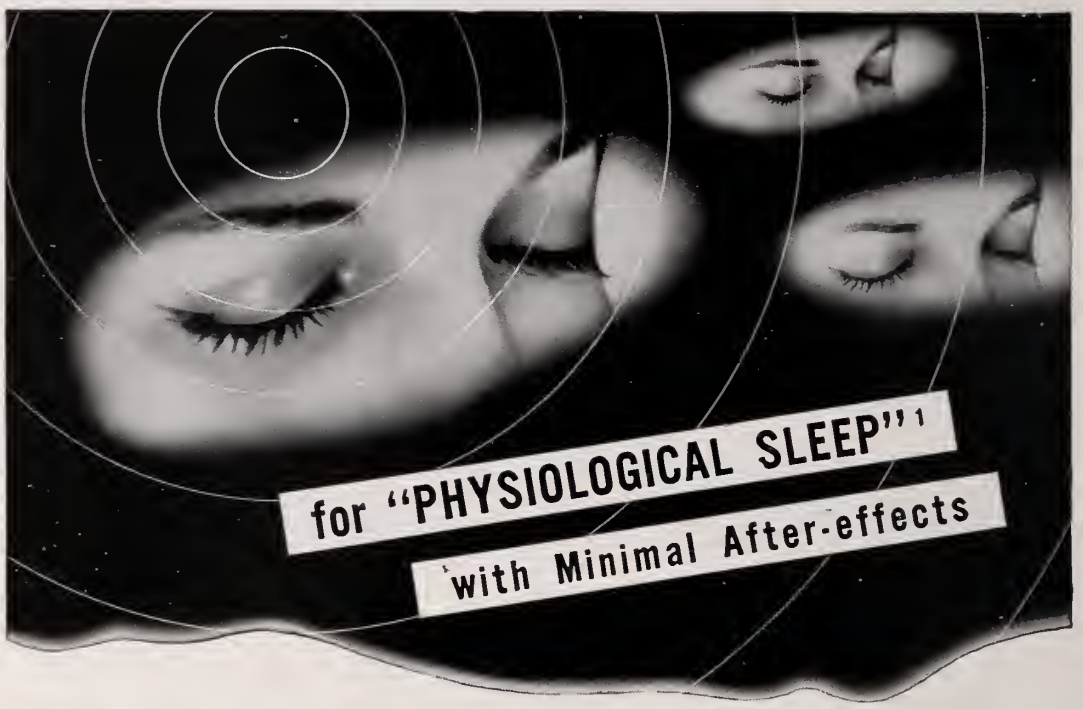
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[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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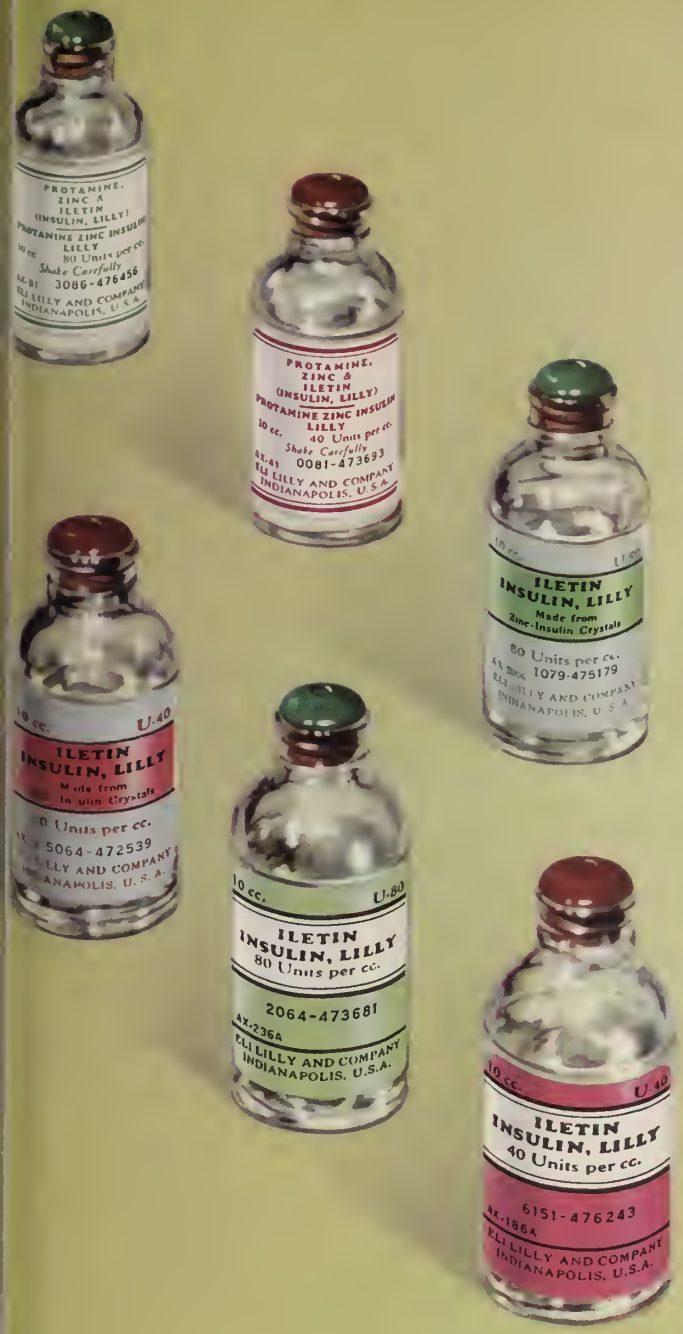
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VOL. XXXIII OCTOBER, 1950 NO. 10

CUTANEOUS CHANGES ASSOCIATED WITH PREGNANCY

ARTHUR B. KERN, M.D.

The Author. *Arthur B. Kern, M.D., of Providence, Assistant Dermatologist, Department of Dermatology, Rhode Island Hospital.*

AMONG the inconveniences, discomforts and ills which befall the pregnant woman, by no means unimportant are those changes of her skin which may develop. Whereas many are of only minor significance, some are exceedingly grave. The cutaneous changes associated with pregnancy may be placed in two groups: (1) those in which a new eruption appears and (2) those in which pregnancy alters a pre-existent dermatosis. Costello[1] divided them into those of endocrine causation, due to diminution or increase in the anterior pituitary sex hormone, and those of toxic and neurogenic origin. However, the specific pathogenesis of many of these dermatoses is as yet unknown and, therefore, a non-etiologic classification is perhaps preferable.

Group I. Dermatoses Induced By Pregnancy

A. *Palmar erythema.* This may take the form of a diffuse, mottled erythema involving the entire palmar surface or may appear as a diffuse redness which is most prominent over the hypothenar and thenar eminences. The erythema tends to increase in intensity as pregnancy progresses. The most complete study of this condition has been conducted by Bean et al[2] who reported their observations on 484 white and 759 negro pregnant women. They found palmar erythema present in 62.5 per cent of the former and 35.0 per cent of the latter. This is in contrast to an incidence of 5.1 per cent and 4.0 per cent in normal white and negro women respectively. Of the white pregnant females, the dermatosis was present by the second month in 33.0 per cent with a gradual rise from then to the ninth month. Six to seven weeks following delivery the erythema had faded in all but nine per cent. Of the negro women, palmar erythema had appeared in 17 per cent by the third month and seven weeks postpartum only four per cent still showed the erythema.

B. *Vascular spiders.* The first observation of spider nevi appearing during pregnancy and disappearing after its termination was recorded by Corbett[3] in 1914. As described by Bean[4], the vascular spider is characterized by three main features—body, legs and surrounding erythema. The body is the central point; it varies in size and when large and elevated may be seen to pulsate. The legs are the branching vessels which radiate from the center. An area of erythema surrounds the body and in most cases extends several millimeters beyond the clearly visible legs. The lesion is bright red and is usually warmer than the adjacent skin. Bean et al[2] found vascular spiders in 66.6 per cent of white and 11.4 per cent of negro pregnant women. In a series of white women who had borne children in the past they were present in only 10 per cent. Fourteen per cent of the white women had these lesions by the second month of pregnancy, while among the negro women none were observed prior to the fourth month, at which time they were seen in 8 per cent. By the seventh post-partum week three-quarters of the women who had vascular spiders in the ninth month of pregnancy had lost them.

Suggesting a common cause was the fact that palmar erythema was observed in 67 per cent of the white women who had vascular spiders, while the latter were present in 71 per cent of those with palmar erythema. Tests of liver function failed to reveal any significant signs of hepatic damage. The incidence of these lesions was no greater in the pregnant women with hypertension or toxemia. They concluded that palmar erythema and vascular spiders are caused by hormones, the estrogens in particular.

C. *Subcutaneous hemangio-endothelioma.* These are usually single, pigmented, warty growths with dilatation of the surrounding veins. Histologically the structure is that of a simple nevus, although malignant degeneration has been noted. Davis[5] observed 11 cases of subcutaneous hemangio-endothelioma in pregnancy. They may appear for the first time during pregnancy, usually in the latter

continued on next page

half, or pre-existing lesions may show a rapid increase in size.

D. *Thrombocytopenic purpura.* This is a serious, but fortunately rare, complication of pregnancy. Polowe[6], in 1944, was able to find 62 such cases recorded in the literature. As pointed out by Patterson[7], most of the patients had had no evidence of purpura prior to pregnancy. Of the 47 cases Rushmore[8] collected from the literature, 43 showed the first sign of purpura after the fourth month of pregnancy. In many the earliest manifestation of the disease was cutaneous purpuric lesions.

E. *Urticaria.* As stated by Pollitzer[9], urticaria is so common a condition that one might hesitate to associate it in causal connection with the state of pregnancy. However, the frequency with which it has been observed in pregnancy, plus the fact that in many women it recurs during each period of gestation with disappearance following delivery suggests that such a causal relationship does exist. Pollitzer attributed the condition to a toxic substance.

F. *Impetigo herpetiformis.* This usually fatal disease is fortunately rare. It is characterized by the presence of groups of small pustules on inflammatory bases. The eruption appears first in the groin or inner surfaces of the thighs and extends peripherally by the formation of new groups of pustules in circinate arrangement. After several months large portions of the body may be covered by excoriations, erosions, crusts and pustules. Grayish patches with depressed centers may be observed on the oral mucous membrane. Associated with the cutaneous lesions are severe constitutional disturbances. Fever, chills, vomiting, diarrhea, prostration and delirium may occur. According to Costello[1] the maternal mortality is between 70 and 80 per cent, while Hollander and Vogel[10] state that it is as high as 90 per cent. Although the disease usually occurs during pregnancy or the puerperium, its development in non-pregnant women and in males has been reported. However, Sandler[11] believes that the cases in the latter two groups are not true examples of impetigo herpetiformis. Toxic, endocrine and infectious causation have been suggested.

G. *Herpes gestationis.* This extremely pruritic dermatosis, first described by Bunel in 1811, is accepted by most authors as being no different from dermatitis herpetiformis except that it occurs during pregnancy. In a statistical review of 20 cases of herpes gestationis appearing in 13 women, Downing and Jillson[12] found the average time of onset was 5.3 months of pregnancy. Prognosis is good since the eruption generally disappears following delivery; occasionally it does persist. In some women there is recurrence in later pregnancies. Crawford and Leeper[13] reviewed the records of 50,000 patients at the Boston Lying-In Hospital from 1929 through 1948 and found only 11 cases of herpes gestationis, while Mueller and Lapp[14] in 1944 reviewed the literature of the preceding 10 years and were able to collect just 33 reports of this disease.

The lesions are recurrent papules, vesicles or bullae characteristically in groups and symmetrically distributed over the scapular, trochanteric and sacral regions and the extensor surfaces of the extremities. Eosinophilia of the blood and vesicle or bulla fluid is frequently present.

The cause of the dermatosis is unknown. It is believed by some to result from injury to the vasomotor nerves by toxins arising from ferments of fetal tissue or cells of chorionic villi. Weidman[15] suggested that the degree of pruritus varies with the level of gonadotropic principle. Antoine[16] believed that toxicosis produced by the ovum in association with a virus is responsible. Renal insufficiency[17] with resultant failure to eliminate toxins, liver dysfunction[18] and allergy[19] have also been suggested as causative factors.

H. *Erythema multiforme gestationis.* As stated by Andrews[20], erythema multiforme during pregnancy "is often of the gravest significance and may necessitate abortion." It may develop at any time during gestation and, as in the case presented by Gross[21], may recur in successive pregnancies. Although a single type of lesion usually predominates, one finds an intermingling of macules, papules, vesicles and bullae generally with surrounding erythema and showing a predilection for the neck and extensor aspect of the extremities. Mouth lesions may be present. Kaiser[22] suggested that a toxin due to pregnancy is responsible. Four of the five patients reported by Crawford and Leeper[13] developed erythema multiforme in relation to a complication of pregnancy, e.g. cellulitis, bronchopneumonia. These authors state that this dermatosis "may occur in relation to so many toxic states that it seems hardly entitled to consideration as a unique feature of pregnancy." However, the fact that some women develop this disorder only during pregnancy, with involution following delivery, suggests that certain changes peculiar to the state of pregnancy may be responsible.

I. *Gingival changes.* Alterations of the gingiva during pregnancy have been described under the titles of stomatitis gravidarum, hypertrophic gingivitis of pregnancy, proliferative gingivitis of pregnancy, epulis gravidarum and pregnancy tumor. However, these are probably all slightly different manifestations of the same condition. Most frequently the gums become edematous, dark bluish-red in color and bleed readily. These changes usually commence about the fourth month of pregnancy, gradually increase in severity, and subside shortly after delivery. The more severe form of gingivitis is characterized by the development of

hemorrhagic, proliferative growths from the interdental gingival structures. These tumors also involute spontaneously after parturition. According to Monash[23] these gingival changes are by no means limited to pregnant women, but the fact that they develop so rapidly during the period of gestation suggests "an exaggerated inflammatory response in some women at that time to irritants that normally evoke only a moderate reaction." Altered buccal secretions, altered metabolism, lack of calcium or vitamin C, and toxemia have also been reported as possible causes[1].

J. *Pruritus.* Pruritus may be mild or may be severe enough to justify the termination of pregnancy[24]. It is generalized or localized. In the former, examination usually reveals only linear and punctate excoriations scattered over the body. The most common site of localized pruritus is the genital region. In these cases itching may be due to trichomonal vaginitis, moniliasis, diabetes or vulvar varicosities. When due to an irritating vaginal discharge, the vaginal secretions should be examined for Trichomonas vaginalis or Monilia albicans. Moniliasis of the ano-genital area may be primary and may be accompanied by monilial infection of other areas; the skin is edematous, erythematous and eroded, with a surrounding white, overhanging fringe of epidermis. All individuals with pruritus during pregnancy should have urine and blood tests to rule out the possibility of diabetes. I have observed several cases of pruritus limited to the legs which developed early in pregnancy and disappeared after delivery. This is most probably the result of interference by the enlarged uterus with the return of blood from the lower extremities. The etiology of the other types of non-specific localized and generalized pruritus has not been established. Costello believes they may be on an endocrine or neurogenic basis.

K. *Prurigo gestationis.* This is a pruritic dermatosis, originally described by Besnier, occurring in the later months of pregnancy and disappearing after its termination. It is characterized by the presence of pinhead to lentil-sized papules covered by bloody crusts on the extensor surfaces of the extremities. In severe cases lesions may also be present on the chest, shoulders and scapular regions. Recurrence in successive pregnancies has occurred. Costello[1] states that he had observed this condition in about 2 per cent of the antepartum patients at Misericordia Hospital.

L. *Cutaneous tags.* Brickner[25], in 1906, described small, pigmented, sessile or pedunculated growths appearing predominantly on the neck of women in the fourth to sixth month of pregnancy and disappearing spontaneously after delivery. He gave the name of fibroma molluscum gravidarum to these lesions. Templeton[26] later described the same type of tumor in elderly women and concluded that the growths were due to hormonal changes common to pregnancy and the menopause. His histologic studies suggested that they were simple outgrowths or excrescences of epidermis and corium rather than fibromas or neurofibromas. The tumors are of significance only for cosmetic reasons.

M. *Pigmentary changes.* A physiologic hyperpigmentation of normally pigmented areas, such as the areolae of the breasts, genitals, umbilicus, axillae, circumanal area and linea nigra, is usually observed during pregnancy. Occasionally localized patches of hyperpigmentation are observed on the face (chloasma). In all such cases the intensity of pigmentation increases through the period of gestation and following delivery there is a disappearance of pigment, but the pre-pregnancy lighter shade is never reached.

N. *Miscellaneous.* The striae distensae of pregnancy, due to rupturing of elastic fibers in the skin as a result of stretching and increased tension, are well-known phenomena. In certain women one or more pregnancies have been associated with the development of hyperhidrosis, hypertrichiasis, loss of hair or nail changes.

Group II. Dermatoses Altered by Pregnancy

A. *Neurofibromatosis (von Recklinghausen's disease).* During pregnancy there is frequently an increase in size of the tumors as well as increased pigmentation. A patient with this disease whom I have observed had a tumor of the nose which enlarged so markedly during pregnancy that it hung down below her chin; it was necessary to excise the growth for cosmetic reasons.

B. *Psoriasis.* Cases have been reported[27,28] in which psoriasis cleared up during each pregnancy with recurrence shortly after delivery. However, it is not uncommon for psoriasis to first develop or become exacerbated in pregnancy. In Crawford and Leeper's[13] series, improvement occurred in half the patients while the other 50 per cent became worse.

C. *Atopic dermatitis.* An exacerbation of this dermatosis is not uncommon during or shortly after pregnancy. In those cases observed by the author the increased emotional stress incident to this state seemed a not unlikely cause of the flare-up.

D. *Lupus erythematosus.* The effect of pregnancy upon lupus erythematosus at times poses a very serious problem. Despite its importance, few references to this matter can be found in the literature. Ormsby and Montgomery[29] merely mention that lupus erythematosus may be affected by pregnancy. In reviews of the dermatoses of pregnancy

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by Costello[1] and Hollander and Vogel[10] the subject is not considered. Crawford and Leeper[13] reported 4 cases of chronic discoid lupus erythematosus and 2 of chronic disseminated lupus erythematosus in pregnancy. Of those with the chronic discoid variety, one went through three pregnancies with no ill effect, one became worse but improved within one month after delivery, while the other two experienced dissemination of the disease with death later resulting. The two patients with the chronic disseminated disease went through several pregnancies without difficulty. Beinhauer[30] reported on one woman with subacute disseminated lupus erythematosus who experienced a remission during each of three pregnancies with recurrence following the deliveries, and three patients with the chronic discoid form of whom one had an exacerbation during each of three pregnancies while in the other two the disease remained quiescent during one and two pregnancies respectively. He suggested that pregnancy should be allowed to go uninterrupted in subacute disseminated and chronic discoid lupus erythematosus. Crawford and Leeper expressed the opinion that pregnancy was not a good omen for the subacute and acute disseminated forms. Kanof[31] recently stated that pregnancy should not be interrupted because of lupus erythematosus. At the present time knowledge concerning the interaction of these two conditions is still meager. Ellis[32] has proposed sending out a questionnaire to obtain more information on this subject, a plan which if carried out should prove of considerable value.

E. *Cutaneous tuberculosis.* This is frequently aggravated during pregnancy.

F. *Condyloma acuminatum.* According to Costello[1] venereal warts present at the start of pregnancy may gradually increase in size to the point where they may cause difficulty at the time of delivery.

G. *Acne vulgaris.* The effect of pregnancy upon this condition is not constant. In some women there is improvement during pregnancy, while others experience an exacerbation.

H. *Granuloma inguinale.* If untreated, this disease tends to progress rapidly during pregnancy as the result of increased vascularity of the parts.

I. *Syphilis.* Moore[33] has stated: "If a woman acquires syphilis just before, coincident with, or shortly after impregnation, the usual manifestations of early syphilis are often completely suppressed, or, if present, are milder in degree than in non-pregnant women or men. This beneficial effect of pregnancy on syphilis is not limited to the early stages of the infection, but often extends throughout the lifetime of the patient and affords a considerable degree of protection against the late lesions, especially neurosyphilis." However, Kemp and Menninger[34], after reviewing their series of 767 cases, including syphilitic males, non-pregnant syphilitic females and females who had had one or more pregnancies after contracting the disease, concluded that while pregnancy may inhibit the cutaneous manifestations of early syphilis, it is not solely responsible for the lesser incidence of neuro-syphilis in females as compared to males. Thomas[35] has recently expressed doubt concerning pregnancy's supposed beneficial effect upon the course of syphilis. During a six year period he saw at least 500 cases of dark-field positive early syphilis in pregnant women, the lesions in no way differing from those in non-pregnant females. It was his opinion that neuro-syphilis is no less frequent in women who have been pregnant than in those who have not. The most significant of his remarks were the following: "The effect of pregnancy on syphilis, however, is of minor importance, and more of academic than of practical interest. The important point is that syphilis can have disastrous effects in pregnancy, even in the absence of clinical manifestations." Since Thomas' investigations have indicated that pregnancy is not responsible for false positive reactions, as was the belief in the past, every pregnant woman with a positive serologic test for syphilis should be considered a candidate for therapy. Although the pregnant female, like the non-pregnant one, is subject to a false positive test as the result of a variety of causes, the safest course, with a relatively innocuous drug such as penicillin available, is to treat even the very questionable case rather than miss one true one.

Summary

The cutaneous changes associated with pregnancy are reviewed. Not only may pregnancy result in alteration of a pre-existent eruption, but it may be responsible for the appearance of new dermatoses ranging in severity from the benign vascular spider to the usually fatal impetigo herpetiformis.

References

[1]Costello, M. J.: Eruptions of Pregnancy, New York State J. Med. 41:849 (April 15) 1941.

[2]Bean W. B., Cogswell R., Dexter, M., and Embick, J. F.: Vascular Changes of the Skin in Pregnancy, Surg. Gyn. & Obst. 88:739 (June) 1949.

[3]Corbett, D.: Cited by Bean et al[2].

[4]Bean, W. B.: Cutaneous Arterial Spider, Medicine 24:243 (Sept.) 1945.

[5]Davis, A.: Subcutaneous Haemangio-endotheliomata Associated with Pregnancy, J. Obst. & Gynaec. Brit. Emp. 45:667 (Aug.) 1938.

[6]Polowe, D.: Splenectomy in Pregnancy Complicated by Thrombocytopenic Purpura Hemorrhagica, J. A. M. A. 124:771 (March 18) 1944.

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PERFORATED PEPTIC ULCER*

Five Hundred Cases in Retrospect

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Summary and Conclusions

(1) Five hundred thirty patients diagnosed with acute perforated peptic ulcers have been reviewed.

(2) Except for influence of season, our charts show no essential difference from other published reports in the relation of mortality to such factors as hours of perforation, age, sex, and site of perforation.

(3) Non-operative treatment of a few selected patients may achieve gratifying results.

(4) The 100 per cent mortality rate contraindicates surgery on patients in shock, early or late.

(5) A chart shows factors we find contributing to the sharp decline in mortality rates since 1941.

(6) Rhode Island Hospital results compare favorably with published reports from similar institutions, and in many instances are superior.

(7) The constant sex discrepancy in such factors as incidence, age, site of perforation, mortality, and the opposite reaction of the gastric mucosa to emotional stress implies that causative factors may vary according to sex.

Introduction

THE increasing volume of literature on the subject of peptic ulcer attests to the growing importance of this problem. It is estimated that there are approximately 1,500,000 persons in this country above the age of 30 in whom peptic ulcer will develop during a ten year period, and 10,000 die annually from its complications, i.e. hemorrhage, obstruction and perforation.

This study deals with the most serious complication of peptic ulcer, viz. perforation. The purpose of this review is not to augment the already vast amount of material on this subject, but to analyze a large group in order to bring out certain pertinent facts which have not been adequately dealt with in previous studies.

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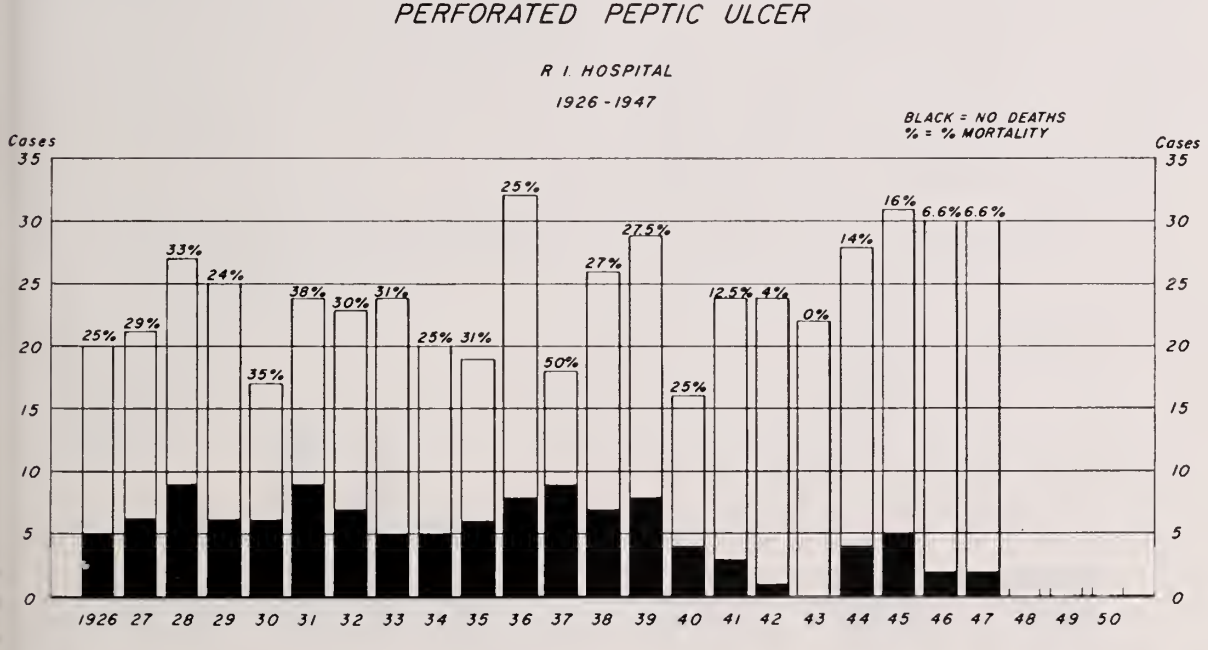


FIGURE 2. ANNUAL INCIDENCE - 1926 1947 - 530 CASES - 117 DEATHS

*From Surgical Service, R. I. Hospital, Providence. Read before the 139th Annual Meeting, Rhode Island Medical Society, at Providence, R. I., May 11, 1950.

Some information regarding the institution from which these cases are reported should be appreciated before examining the material itself. The Rhode Island Hospital is a general hospital of 569 beds with a gross admission rate of 15,702 in 1947. Since most of these patients were emergencies, the greater number of operations were performed by junior members of the staff and, in the last three years, usually by the residents. Many times the operations were performed late at night, and the operators were not committed to any one routine method of treatment. Therefore, each case is, as it should be, treated individually on its own merits. Operative procedures were carried out by 38 different staff members.

As will be seen in the various tables and figures, this group has been divided into three series: Series I, 220 cases, occurring from 1926 to 1935 (which was reported in 1936 before the Rhode Island Medical Society); Series II, 310 cases, occurring from 1936 to 1947; and finally, Series III, combining the previous two groups. Therefore, the 530 cases are consecutive cases admitted to the Rhode Island Hospital during the twenty-two year period (1926-47), in which the diagnosis of acute perforated peptic ulcer was confirmed either at operation or necropsy. It will be noted that in the second series there are more factors reviewed, and the study is more complete. The basic variables to be studied will be culled from the 530 cases, while other factors will be derived from the second series of 310 cases.

Annual Incidence

(Figure 2) The annual admissions over the twenty-two year period show only slight variation. Our figures do not show any appreciable increase during the war years as reported in England. This was probably due to good employment conditions during this period and absence of fear from actual war destruction, thus minimizing mental stress.

Sex Incidence

(Figure 3) One of the most striking features of perforated peptic ulcer is the very low incidence in the female. The discrepancies between the sexes in such factors as age, site and mortality observed in this and other studies would imply that a different causative factor may be at work in the two sexes. While earlier statistics (up to 1915) showed almost an equal number, and in some instances even greater incidence in the female, all reports within the past twenty-five years show a rapid decrease. Our figures bear this out—in the first group (1926-1935) the incidence was 8.6 per cent, while in the second series (1936-1947) it was 4.8 per cent. Why this should be so is the subject of many research projects in such fields as physiology, endocrinology and psychiatry, to mention but a few. Although it is not our intent to elaborate on the cause of this discrepancy in sex incidence, we are impressed by the work of Crider and Walker, who recently reported what appears to be the first opportunity to observe gastric activity in a twenty-one year old negress by means of a gastrotomy. Although the four previous studies in the reaction of gastric mucosa to stimuli, beginning with the famous Alexis St. Martin, were males, this is apparently the first female to be followed in this manner to date. These workers reported that the reaction of the gastric mucosa in this patient was, under similar circumstances, opposite those reported on male subjects; i.e., instead of hyperemia, increased secretion and increased acidity, blanching, diminished secretion, and diminished acidity were recorded. For final proof it will be necessary to repeat the experiment in a white female. This brings up many interesting speculations, such as: Has the female something that protects her from ulcer? Has she a different mode of living? Since her emancipation her mode of living has changed.

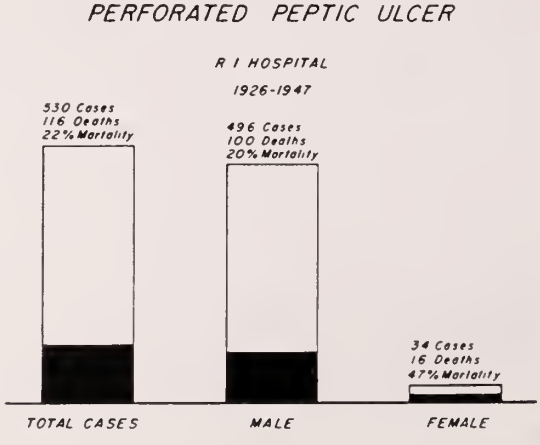


FIGURE 3 SEX INCIDENCE IN 530 CASES

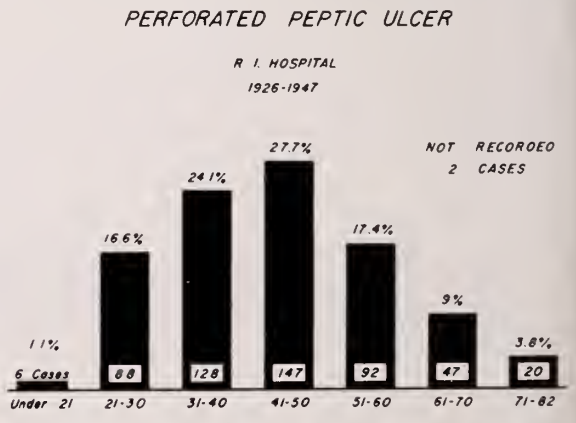


FIGURE 4 INCIDENCE ACCORDING TO AGE - - - - 530 CASES

Age Incidence

(Figure 4) Approximately 68 per cent of perforations occurred in patients under 50 years. The youngest was 16 years, the oldest 84 years. Because of the overwhelming incidence of perforations in the post-menopausal female (only one female patient under 43 years), some observers have suggested that estrogenic imbalance may play a part in the development of peptic ulcer. This theory, however, does not offer explanation for the larger incidence of perforated ulcer in younger females in the earlier reports.

Seasonal Incidence

The influence of season on perforation has been stressed by many clinicians and authors; however, although our study showed a slight increase in spring and summer, it is statistically insignificant. The spring, summer, autumn and winter allocations were respectively 29, 28, 20 and 23 per cent, with maximum cases occurring in spring and minimum in the fall, while spring and autumn had highest mortality. DeBakey reported similar results from Charity Hospital, New Orleans. However, one thing stands out, i.e. spring, having only a slight increase in number of cases, had a much higher mortality. The monthly admissions showed May and August to be the highest. That a "young man's fancy turns to thoughts of love in the spring" with its emotional upsets, may play a part in this increase.

Previous Symptoms

(Figure 5) The majority of patients with perforated peptic ulcer will give a history of previous gastro-intestinal disturbances with duration of months to many years. This chart shows the previous symptoms recorded in this study; while some type of disturbance was obtained in about 90 per

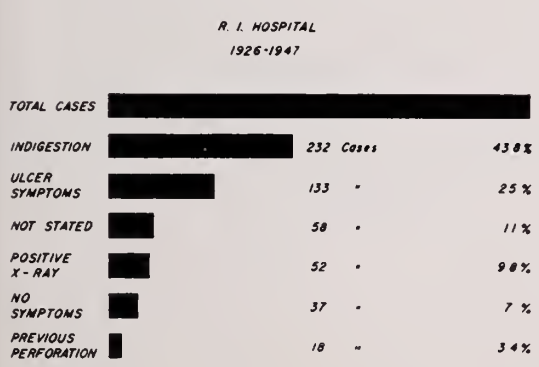


FIGURE 5. INCIDENCE OF PREVIOUS SYMPTOMS IN 530 CASES

cent of the patients, typical ulcer symptoms were recorded in only 25 per cent. Previous perforation was recorded in 3.4 per cent. Of practical importance is the fact that the absence of previous symptoms was more common in the older group and in the very young.

Presence of Pneumoperitoneum

(Figure 6) This chart shows the result in 161 patients who were X-rayed for the demonstration of air under the diaphragm. The presence of air under the diaphragm in perforation is given all the way from 50 to 85 per cent. Many of the failures in demonstrating air are due to poor technique. It is important in making out the X-ray requisition to state what you are looking for, rather than merely request a flat film of the abdomen. Most good X-ray technicians know the proper technique. Our figures show 73.3 per cent positive and a corrected positive in 83.3 per cent. It is our opinion that if a proper

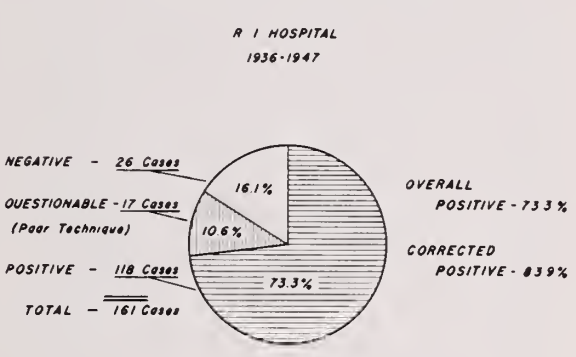


FIGURE 6 INCIDENCE OF PNEUMOPERITONEUM - 161 CASES

X-ray requisition is made out, a good technician will demonstrate air under the diaphragm in almost 90 per cent of the cases. We wish to emphasize that all patients with an abdominal catastrophe should have a flat X-ray film of abdomen on their way to the ward. We believe that the demonstration by X-ray of air under the diaphragm in an acute surgical abdomen, in a male patient, means a ruptured viscus, and in the absence of abdominal trauma, perforated peptic ulcer will be found to be the cause in almost 100 per cent. Of the 118 cases showing air, 40 were bilateral and 78 unilateral. Of the cases showing bilateral air, the perforation was more likely to be gastric than duodenal.

Diagnosis

The diagnosis of acute perforated peptic ulcer presents no problem in about 90 per cent of the cases. The classic and dramatic picture of sudden, severe epigastric pain, with or without vomiting, and soon followed by a tense and board-like abdomen, is well known to all medical students. The history of previous gastro-intestinal disturbance is a valuable aid in making a correct diagnosis. As stated above, 90 per cent of the patients in this group gave a history of previous gastro-intestinal disturbance.

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Physical examination of the abdomen reveals true boardlike rectus rigidity with the point of maximum tenderness in the mid-epigastrium; obliteration of liver dullness is noted in approximately 70 per cent of the cases when the perforation is on the anterior surface of the duodenum or stomach.

Undoubtedly, one of the most valuable signs in perforation is X-ray demonstration of air under the diaphragm. Although the absence of air in a surgical abdomen does not exclude perforation, the presence of air in a patient suspected of having a perforated ulcer may be considered for all practical purposes a pathognomonic sign. Confusion in correct diagnosis is noted during alcoholic sprees or in patients suspected of having heart or gall bladder disease. Here the diagnosis has often been missed or discovered too late for good operative results. It is interesting to note that in five cases in which a diagnosis of myocardial infarction was made as confirmed by apparently consistent electro-cardiographic changes, there were no signs of myocardial damage to be found in any of the cases at autopsy.

Patients seen late with peritonitis also present difficulties in diagnosis, especially if they have not had an X-ray of the abdomen or, having had it, no free air has been demonstrated. The diagnosis usually made in these cases is intestinal obstruction with general peritonitis. In the early cases the most common error in diagnosis is acute appendicitis in the male, and acute cholycystitis in the female. This confusion with appendicitis arises because of localized and rebound tenderness over McBurney's point. This is due to peritonitis from a fluid collection in the right lower quadrant. This confusion may be avoided if it is remembered that appendicitis rarely presents tenderness in the epigastric region, while in perforation tenderness and moderate rigidity over the right lower quadrant is frequently encountered. In two cases in which the pre-operative diagnosis was acute appendicitis, X-ray of the abdomen showed air under the diaphragm, but the films had not been viewed before the operation.

Another type of case in which the diagnosis may be confusing is the atypical early case known as the "formes frustes", or the "dry" type of the English surgeons. In this type nature quickly seals the small perforation following the acute attack, and unless the patient is seen soon after the initial attack the usual abdominal symptoms are absent. These patients if treated intelligently require no operation for the perforation. We had six patients falling into this group; three were not operated upon, two underwent surgery but nature had done such a perfect job that the sealed-off area was not disturbed. In the other, the protective adhesions were broken up and the perforation sutured. The sixth case refused operation.

In the second series of 310 cases, acute appendicitis was the pre-operative diagnosis in 5 (1.6 per cent), acute cholecystitis 3 (1 per cent), coronary thrombosis 5 (1.6 per cent), ectopic pregnancy 1 (.3 per cent), incarcerated hernia 1 (.3 per cent), acute urinary retention 2 (.6 per cent), acute ileitis 1 (.3 per cent). The other 12 incorrect diagnoses included such illnesses as acute pancreatitis, mesenteric thrombosis, and intestinal obstruction.

When dealing with the acute surgical abdomen a correct diagnosis is always desirable, but perhaps not as important as the proper treatment of the emergency. We are all aware, all things being equal, that operation with negative findings does less harm than delay in trying to make a correct diagnosis. All cases in which an incorrect diagnosis was made, but indications for operation were present, made uneventful recoveries.

Site of Perforation

(Figure 7) The majority of perforations occurred in the first portion of the duodenum (66.6 per cent). At the time of operation because of edema, it may be difficult to be certain whether the perforation is proximal or distal to the pyloric

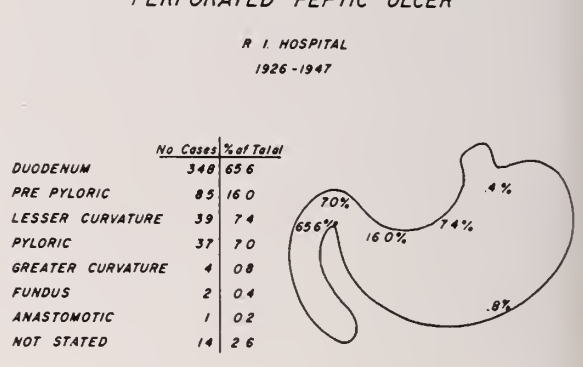


FIGURE 7. ACTUAL SITE OF PERFORATION IN 530 CASES • - - - •

ring. However, in 33 deaths with autopsy there was good correlation between the exact site of perforation and site determined at operation. Figure 7 also

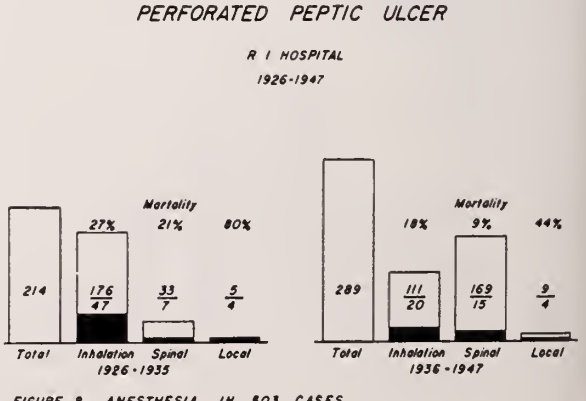


FIGURE 8. ANESTHESIA IN 503 CASES

shows the so-called ulcer bearing area, where 96 per cent of the perforations took place. This area includes the first portion of the duodenum and the lesser curvature of the pyloric portion of the stomach.

Anesthesia

The type of anesthesia employed is shown in Figure 8. In the first series general anesthesia was employed in the majority of cases, while in the second series spinal anesthesia was the anesthesia of choice. It will be noted that the mortality in general anesthesia in the second group was twice as high as with spinal. However, this does not mean that spinal anesthesia is twice as safe as inhalation anesthesia. The records show that one surgeon who used inhalation anesthesia in all his operations had no deaths. The choice anesthesia is the anesthesia best suited for the individual patient.

Multiple Perforations

Multiple perforations in gastro-duodenal ulcerations occur relatively rarely. No multiple perforation was recorded in this study, while the incidence of multiple ulcers in 52 autopsies was recorded 13 times (25 per cent). Many writers reported results similar to ours, while others reported .8 to 1 per cent multiple perforations. The incidence of multiple ulcers is given as 25 per cent in duodenal and 5 per cent in gastric.

Treatment

Once the diagnosis of perforated ulcer is made, immediate operation, with due regard to the patient's overall general condition, is still the treatment of choice. However, as already stated, in the so-called "formes frustes" type, operation is not imperative, and in late cases that are progressing satisfactorily operation may be delayed or avoided. Recently, a number of reports have appeared advocating non-operative treatment in selected cases with excellent results. Figure 9 shows the actual operative procedures carried out in 505 patients in both series. In the second series there were four early cases treated conservatively, with recovery in all four; in three of the cases it was the method of choice, while in the fourth the patient refused operation; all the other non-operative cases were late and all died. Simple closure with omental patching is considered the operation of choice by most surgeons

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PERFORATED PEPTIC ULCER

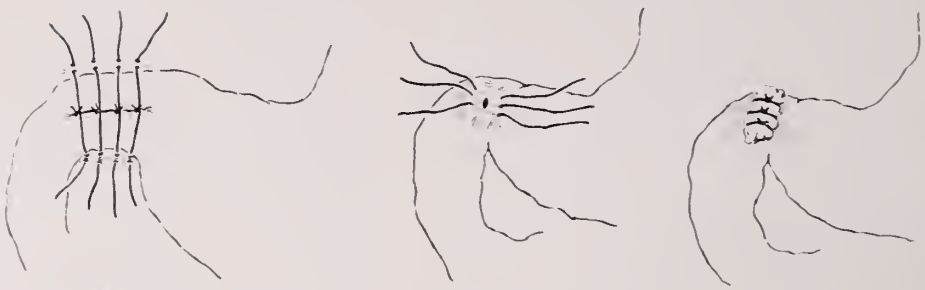
R. I. HOSPITAL

1926-1947

PRIMARY OPERATIVE PROCEDURES	1926-1935		1936-1947		TOTALS		
	Cases	Deaths	Cases	Deaths	Cases	Deaths	% Mort.
Simple Closure	180	41	236	32	416	73	17.5
Partial Closure	5	1	3	1	3	2	25
Omental Patching	1	1	6	0	6	0	0
Closure Plus Excision Ulcer	6	4	11	0	17	4	23.5
Closure Plus Appendectomy	-	-	8	1	8	1	12.5
Closure Plus Gastro Enterostomy	8	1	3	1	11	2	18.2
Closure Plus Cholycystectomy	-	-	2	0	2	0	0
Closure Plus Late Gastrectomy	-	-	3	0	3	0	0
Closure Plus Ophorectomy	-	-	1	0	1	0	0
Excision Ulcer With Pyloroplasty	2	1	2	0	4	1	25
Excision Ulcer Plus Gastro-Enterostomy	-	-	1	0	1	0	0
Gastrectomy Primary	1	0	2	1	3	1	33.3
Gastro-Enterostamy Late	-	-	1	0	1	0	0
Laparotomy With Drainage	10	9	6	2	16	11	68.7
Celiotomy	-	-	1	0	1	0	0
Drainage of Pelvic Abscess	-	-	1	0	1	0	0
Drainage of Sub-Phrenic Abscess	1	0	3	0	4	0	0
Drainage of Sub-Hepatic Abscess	-	-	1	0	1	0	0
Colostomy	1	1	-	-	1	1	100
No Operation	6	6	19	15	25	21	84
TOTAL	220	64	310	53	530	117	22

FIGURE 9. OPERATIVE PROCEDURES IN 530 CASES

PERFORATED PEPTIC ULCER



-A-

MODE OF CLOSURE OF DUODENAL ULCER, WHETHER PERFORATING OR NOT. THE ULCER IS INFOLDED AND THE GASTRO-HEPATIC AND GASTROCOLIC OMENTA ARE SUTURED OR LIGATURED TOGETHER OVER THE INTESTINE.

Moynihan in "Abdominal Operations"

-B-

THREE INTERRUPTED CATGUT SUTURES PLACED BUT NOT TIED.

SUTURES TIED OVER FREE OMENTAL GRAFT.

Roscoe Graham in "American Journal of Surgery," Dec.'46

FIGURE 10. -A- MODE OF CLOSURE -B- REPAIR OF PERFORATION WITH OMENTAL GRAFT

in this country and in England. Figure 10-A illustrates the usual mode of closing the perforation, by infolding the ulcer and suturing the gastro-hepatic and gastro-colic omenta over it, while Figure 10-B shows the simpler method of placing a graft of omentum over the perforation and sutures tied over the graft. This simulates more closely nature's method of sealing the perforation.

The essentials of non-operative treatment are, gastric suction with a Levin tube, use of intravenous fluids and the use of antibiotics.

Post Operative Complications

It will be noted that the complications are the usual ones following abdominal surgery: pulmonary disturbances, peritonitis, and localized collections of pus were most frequent. One interesting feature in this whole study was the very low incidence of thrombo-phlebitic complications. In the early group there were two cases of pulmonary embolism and one of thrombo-phlebitis, while in the second group only one case of thrombo-phlebitis with recovery was reported. There were no femoral vein ligations recorded. The fact that over two-thirds of the patients were under 51 years of age may have some bearing on this.

Prognosis

The mortality in acute perforated peptic ulcer depends on a number of factors, some controllable and others uncontrollable by the surgeon. The uncontrollable factors are age, sex, site of perforation, and the duration of perforation; the relation of these factors to mortality will be shown in the different charts.

The annual mortality incidence for the twenty-two year period is shown in Figure 11. It will be noted that with few exceptions there was slight variation up to 1940; from 1941 a marked decrease in mortality took place and has continued since then. In our opinion the factors which have influenced this reduction in mortality since 1941 are: (1) intelligent application of methods to correct disturbed physiology, (2) improvements in anesthesia, (3) simplest technique in closing the perforation, (4) the use of antibiotics, (5) non-operative procedures on patients in shock.

Relation of Mortality to Hours of Perforation

It is common knowledge that the most important factor in the prognosis is the time relation between perforation and surgery. Figure 12 shows, other things being equal, the mortality increases in an almost arithmetic progression (with the exception of the 18 hour group), i.e., the prognosis is twice as good if surgery is performed within the first twenty-four hours; likewise, recovery is twice as certain if surgery is performed within the first thirteen hours.

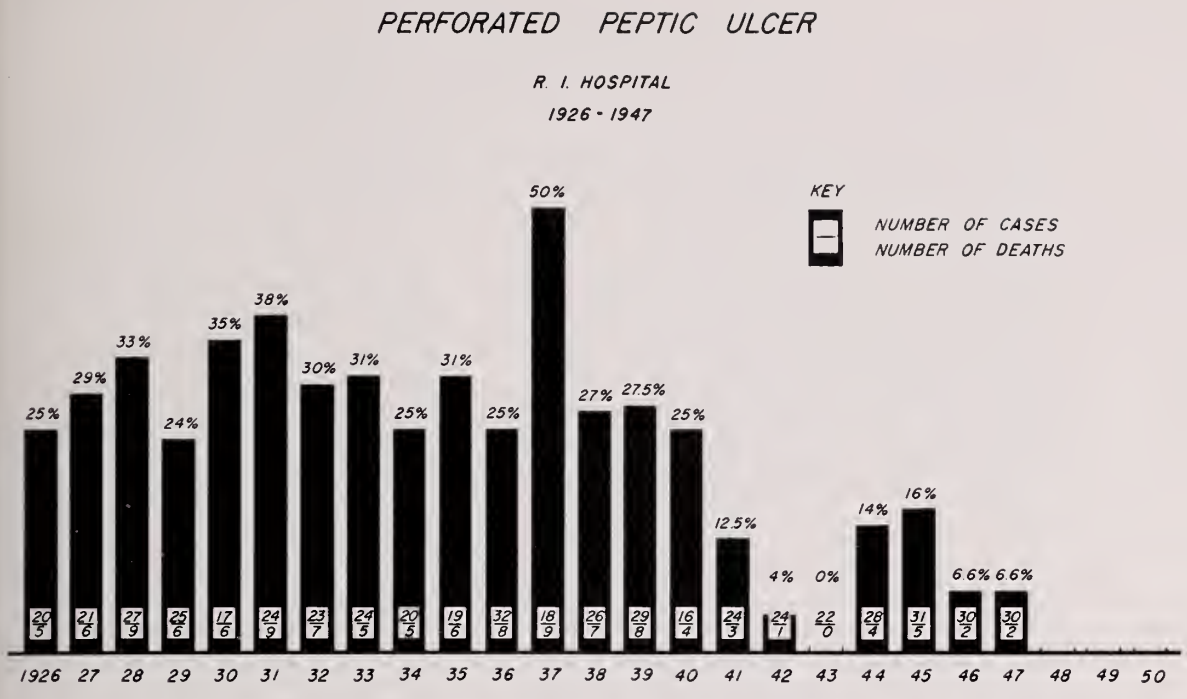


FIGURE 11. ANNUAL MORTALITY INCIDENCE - PERIOD 1926-1947 530 CASES - 117 DEATHS

The significance of the age factor in the prognosis is a well-known fact. In the 310 patients of the second series, the mortality rate was around 2 per cent in the second and third decades, and 11, 17 and 16 per cent respectively in the fourth, fifth and sixth decades, while in the seventh decade the mortality was doubled (31 per cent) and the eighth decade, 60 per cent.

It has been generally recognized that the sex factor is also significant in the prognosis of perforated ulcer. Our figures show, as in other published reports, that mortality in the female is twice as high as in the male, while the incidence of perforation is much greater in the male. Although no satisfactory explanation for this fact has been offered, two factors in this study may be significant, i.e., the greater incidence of gastric ulcers and the larger number of older patients in the female group.

Figure 13 shows that the site of perforation is also a factor in the prognosis. While some observers have reported a higher mortality in duodenal ulcers, the majority of authors have reported figures similar to ours, viz., the mortality in gastric perforations is at least ten per cent higher.

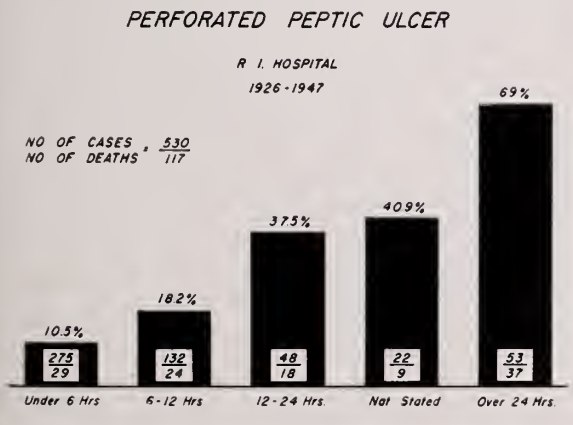


FIGURE 12. RELATION OF MORTALITY TO DURATION OF PERFORATION

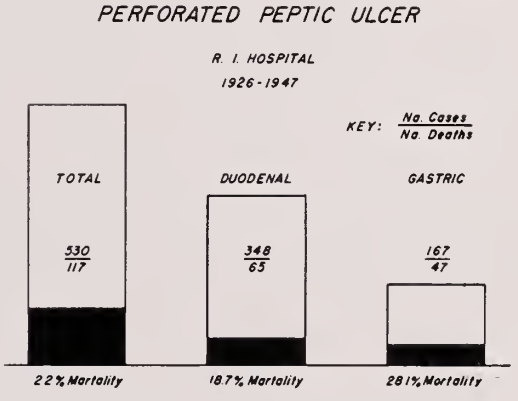


FIGURE 13. RELATION OF SITE TO MORTALITY

Comparative mortality rate in selected published series is shown in Figure 14. It is noted that the low mortality in the last five years at the Rhode Island Hospital is surpassed only by Baritel; however, his patients were all males and the operations were performed by two surgeons in a private hospital.

continued on next page

PERFORATED PEPTIC ULCER

AUTHOR	SOURCE	Period of Study	No. of Cases	Total Mortality	Operative Mortality
Boritell	Permante Foundations Hospitals	1943-46	88	1.1%	1.1%
Black & Blockford	Mayo Clinic	1935-45	96	12.0	8.6
De Bakey	Collected Series	1940	16,752	25.2	23.4
De Bakey	Chority Hospital	1940	211	18.9	18.2
Graham	Toronto Generol Hospital	1929-45	125	10.0	6.4
Kingsbury & Schilling	Roosevelt Hospitol, N.Y.C.	1930-42	224	13.4	12.6
McCabe & Mersheimer	Metropoliton Hospitol, N.Y.C.	1930-41	87	25.2	25.2
Moore & Hendricks	Bellevue Hospitol, N.Y.C.	1928-45	101	18.0	18.0
Olsen & Norgore	King County Hospitol, Seottle, Wosh.	1938-44	166	27.7	21.0
Shipley & Wolker	University Hospitol, Baltimore	1935-46	200	26.0	20.0
Corvese	R. I. Hospitol	1926-47	530	29.1	18.0
Corvese	R. I. Hospitol	1936-47	310	17.0	13.0
Corvese	R. I. Hospitol	1943-47	141	9.2	5.1
Illingworth	Vorious Hospitols in the West of Scotlond	1924-43	7,156	19.5	Not Stoted
Sondberg	Surg. Clinic & Gorrison Ward of Korolinsko Sjukhuset, Sweden	1940-44	110	10.9	9.5
Toylor (Non-Op)	King George Hospitol, England	1946	28	14.0	
Trinco	Melbourne Hospitol, Australia	1920-46	568	15.4	15.4
Yudin	Centrol Emergency Hospitol, Moscow	1933-34	426	14.0	12.8

FIGURE 14. COMPARATIVE MORTALITY RATES IN SELECTED PUBLISHED STATISTICS

We wish to thank Dr. W. P. Davis, former surgical chief, and Dr. J. Murray Beardsley, present surgical chief, for their cooperation; the personnel of the record room for their patient willingness to get the records; Miss Doris Johnson, the librarian; Mr. George Mancini, for making the slides; and Mr. Warren Luther, who made the charts.

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LIBRARY CLOSED SATURDAYS

With the approval of the Council the Board of Trustees announces the closing of the Medical Library on Saturdays throughout the year. This decision was reached after a study of the use of the building on Saturday mornings when it has been open from 9 a.m. until noon. The expense of opening and heating the building for this three hour period does not justify the continuance of the practice.

Medical Library hours effective October 1, 1950 will be as follows:

DAY HOURS

MONDAY through FRIDAY (holidays excepted) 9 a.m. until 5 p.m.

EVENING HOURS

TUESDAY, WEDNESDAY, and THURSDAY (Holidays excepted) 7 p.m. until 10 p.m.

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106 Francis Street, Providence, Rhode Island

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DEFENSE

OF COURSE we must all be ready now for defense measures at home. The days are gone when the ablest young men went out to fight, and the old folks, women and children remained behind in relative security. War is frankly philosophical now, and the enemy is going to attack the civilian population if he can. He now possesses the means to come great distances for this purpose, so we must expect this and make preparations in advance.

It is safe to say that if we ever are put to the test, the problems will be altogether different from any dealt with before in this country. In the last war the Hartford Hospital took measures to deal with a catastrophe. They thought that one of their great manufacturing plants might be bombed. This didn't happen, but the circus fire was of somewhat commensurate gravity. The hospital was ready, responded efficiently and did an excellent job.

We have seen the program that the Rhode Island Hospital has developed to meet a similar situation in this war. This is excellent as far at it goes. We can hardly expect though that the enemy will come thousands of miles to drop a block buster even on our most important industrial plant.

If an atom bomb or some more hideously destructive weapon of warfare lands upon Hartford or Providence, the local hospitals in the immediate vicinity will have no problems. Everything human in that vicinity will cease to exist. The population a little farther away, badly injured but still alive, will have to be succored by relief parties from other medical centers.

We will now be on the firing line; martial law will have to be in effect, and orders will have to come from headquarters. Warfare is the very apotheosis of socialism and bureaucracy. Individual human rights are of the minutest importance. We will have to recognize this and act only as parts of the all-powerful state.

The Governor of Rhode Island has appointed a Civilian Defense Committee. These able and influential men will plan to the best of their powers for our little state, but they will expect to cooperate with the other states as part of a vast plan headed by the federal government. It is fitting that each city and town consider these matters but always with the understanding that they are yet another step down.

The meek medical profession will find it easy to accept their place on still a lower level. In the first world war a group of doctors and nurses were organized and left at short notice for stricken Halifax. If any community is blasted in this war, we must have our supplies and personnel ready for just as prompt action.

It would be presumptuous for us to discuss details of any projected program. Presumably the enemy will direct any attack to the dense centers of population. Here is where our hospitals are, and here are stored our most vital supplies.

continued on next page

There undoubtedly are, here and there in the country, large buildings or collections of buildings that could be improvised into hospitals. One of the larger hospitals of Munich had been partially destroyed in the last war. In what was left they did the surgery which required prompt action and all that could be handled in a slower manner was sent to a hospital in the country. Such matters should be considered in advance and be ready on paper at least. It would seem that hospital and medical supplies should also be in numerous widely separated storehouses. The old adage about having all one's eggs in a single basket is peculiarly applicable when bad boys are tipping over baskets.

We do not know whether there are any worthwhile precautions that can be taken by the civilian population to minimize the effects of atom bombers. At the December meeting of the Rhode Island Medical Society to be held in Woonsocket, two speakers who have studied this subject will give information and advice that they have. Presumably we may expect some directives soon from the central government. Until that time, we must keep our equanimity. We undoubtedly will be found ready and willing to do our part to the best of our understanding.

TWO DELEGATES NEEDED

The adoption by our House of Delegates last month of a resolution requesting the House of Delegates of the American Medical Association to amend its by-laws to permit each state and territory to have at least two delegates should be given favorable consideration at the Cleveland meeting in December.

Twenty state and territorial medical associations, including Rhode Island, are now permitted but one delegate. Apportionment is based on active membership of the state association, with one delegate permitted for each 1,000 active members or fraction thereof. The twenty states with memberships within these limits are faced with the same problems of the major states, whether the issue is national, regional, or local. But the task of keeping abreast of the transactions at the annual and semi-annual meetings of the AMA House of Delegates is an impossible task for a single delegate.

The many resolutions poured into the legislative body have in too many instances a direct bearing on local problems, but no one delegate can attend the many reference meetings, which conflict in their meeting times, to express local views or to become thoroughly familiar with the pros and cons which result in the final amended resolution brought back into the legislative body and upon which he must vote intelligently and in the best interests of his own association.

Proposed changes, particularly to by-laws, always evoke opposition, and we anticipate that some of the larger state associations who may be jealous of the superior voting power resting with their representation may resent the increase in the delegation to the twenty states and territories concerned directly by this resolution. But political effects should be ruled out of the resolution we are to submit. Today the American Medical Association needs the strongest possible support from its component units. No longer is AMA membership a gift. If the membership in the smaller states is to secure the full advantages that should accrue to them by a larger delegation in the House, that representation should be granted.

Certainly the organized state medical association, however small in membership, has more at stake in the transactions of the AMA House of Delegates than any of the 17 specialty groups that are primarily concerned with their own field. Yet each of these specialty groups is entitled to the same representation as twenty states and territories!

The AMA House of Delegates can resolve this issue favorably at its December session in Cleveland by a two-thirds affirmative vote of the House membership. We sincerely hope it will.

1950 DIABETES DETECTION DRIVE

Diabetes Detection Week this year has been set for November 12-18.

Every Fellow of the Society has been alerted to this program by communications from the Committee on Diabetes. This campaign is a voluntary one, and it promises to become one of the outstanding examples of preventive medicine in which the profession and the public can cooperate at minimum expense.

Last year, through the planned and concerted effort of many individuals and agencies, more than 7,000 urine samples were tested, free of charge, by physicians, hospitals, health departments, and private laboratories. This public response to the first campaign which was launched with limited publicity is indication of the general interest that can be aroused in any sound program whose objective is to improve the health of the public.

This year the campaign will be supported by wider publicity and by a public awakened to the significance of the program. As a result every physician should take far more than a casual cooperative interest in the task of educating his patients to the importance of urine tests. He should also accept willingly the request of the committee to make this a public relations program of far reaching effect.

As we have noted before in these columns, "the discovery of the disease in its early stages will definitely mean the possibility of a longer and happier life for the individual concerned, as well as the avoidance of those complications that occur when diabetes is allowed to reach a serious stage before treatment is instituted."

COMMITTEE ON RESCUE

ELSEWHERE in this issue (see page 542) is a description and explanation of the objectives of the committee on rescue of the Governor's Fire Prevention Conference. Every physician should read this brief article. More important, every physician should become familiar with the Rescue badge illustrated in connection with the report.

At the annual meeting of the Society last May the rescue division of the fire department demonstrated its truck in front of the Library building, and a year ago the Providence unit put on a remarkable demonstration at one of the meetings of the Providence Medical Association.

These specialized rescue units are available on call by any physician. The trained men manning the rescue equipment are prepared for practically any emergency from hoisting a highway wreck to providing oxygen therapy. They are instructed to work with and under medical supervision, and they will respond to a home emergency as quickly as they will to a highway disaster.

Every physician in the state should make it a point to become familiar with the rescue facilities in his local area, for the program is a statewide one, and fire department units have been trained in every locality. These units will welcome local medical advice. They will be prepared to serve the physician when needed.

Recognize the wearer of the Rescue Badge as a trained technician upon whom you can rely in an emergency.



New York DAILY NEWS

Wednesday, September 13, 1950 Tel. MUrray Hill 2-1234

GEORGE KICKS KARL IN TEETH

George Bernard Shaw, 94-year-old dramatist, trips over some pebbles in his British back yard, breaks a thighbone, and is shipped to a nearby hospital for an operation.

The old rooster has been a Socialist since the Later Bronze Age or thereabout. Socialist medicine is now in full blast throughout Great Britain. All ordinary medical services are "free," meaning paid for out of taxes, so you get the pleasant illusion that it's costing you nothing when you accept such aid.


G. B. Shaw

Does Shaw go in for Socialist medicine in this case? He does not. He's one of the rotten rich whom he has always professionally denounced, and stingier with his dough than almost any other living wealthy person. Nevertheless, he kicks old Karl Marx, founder of Socialism, in the teeth. Shaw demands a private room at $6.08 a day, for which he will have to pay out of his own fishhooked pocket, and specialist services, for which he will also have to pay.

When top-drawer Socialists like Shaw, Attlee and Bevin can't take their own brand of Socialist medicine, just how good or how desirable for anybody is that medicine?

THE JOHN F. KENNEY MEMORIAL CLINIC DAY
of
THE MEMORIAL HOSPITAL INTERNS' ALUMNI ASSOCIATION
at
THE MEMORIAL HOSPITAL
Pawtucket, Rhode Island
on
WEDNESDAY, NOVEMBER 1, 1950
LOCATION: *Auditorium, Brewster Street*

MORNING SESSION (10:00 A.M. to 12:30 P.M.)

G. RAYMOND FOX, M.D., *Chairman*

10:00 to 10:20 "NERVE BLOCK — DIAGNOSTIC AND THERAPEUTIC" Edward Damarjian, M.D.

10:25 to 10:45 "SOME MEDICAL ASPECTS OF OPHTHALMOLOGY"
Raymond F. Hacking, M.D.

10:50 to 11:10 "ANTICOAGULANT THERAPY IN THROMBO-EMBOLIC DISEASE"
Jacob Greenstein, M.D.
Henry E. Turner, M.D.

11:15 to 11:35 "COMPLICATIONS OF GASTRIC OPERATIONS" Orland F. Smith, M.D.

11:40 to 12:00 "CONSERVATIVE MANAGEMENT OF LOWER NEPHRON NEPHROSIS"
Ernest K. Landsteiner, M.D.

12:05 to 12:25 "HYPERTROPHIC PYLORIC STENOSIS"
(Illustrated by Motion Picture)
Earl F. Kelly, M.D.
William P. Davis, M.D.

12:30 to 1:55 BUFFET LUNCHEON

AFTERNOON SESSION (2:00 to 5:30)

INTRODUCTORY REMARKS: Mihran A. Chapian, M.D., President,
The Interns' Alumni Association

GREETINGS: The Honorable John O. Pastore, Governor of Rhode Island
Mr. Kenneth D. MacColl, President, The Memorial Hospital

"LESIONS OF THE STOMACH AND DUODENUM"
Frank H. Lahey, M.D., Director of The Lahey Clinic; Former President of the American Medical Association

"LESIONS OF THE ESOPHAGUS AND THEIR SURGICAL MANAGEMENT"
Herbert D. Adams, M.D., Department of General Surgery, The Lahey Clinic

"KIDNEY TUMORS"
Vernon S. Dick, M.D., Department of Urology, The Lahey Clinic

"DISEASES OF THE SPLEEN"
John W. Norcross, M.D., Department of Internal Medicine, The Lahey Clinic

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SQUIBB

RHODE ISLAND COMMITTEE ON RESCUE

— Description and Objectives of the Committee on Rescue of the Governor's Fire Prevention Conference —

ABOUT three years ago the Rhode Island State Fire Marshal, who at that time was Colonel E. Ralph Bonat, recognized the need for a group of trained men who were willing and ready to respond in cases of varied disasters and accidents. Colonel Bonat called ex-Fire Chief Charles Quinn to head up the Committee on Rescue. This was an excellent selection as Mr. Quinn has had a wide practical background not only in actual rescue work, but also in the field of fire-fighting and fire prevention.

Since the Fire Department is generally well equipped with necessary apparatus for rescue and is manned by personnel interested in the safety and welfare of a community, Chairman Quinn has directed his educational efforts in their behalf. Consequently, meetings have been held at the Rhode Island College of Education at which time specialists on refrigeration, elevators, electricity, First Aid, Oxygen Therapy and numerous other topics that would inform the fireman of the extent and limitations of his job have been presented. Statewide attendance has been evidenced at the meetings which conclusively proves a wholesome interest designed to aid and assist persons in distress.

Lt. Leslie O'Brien, Deputy State Fire Marshal, Lt. Charles Potter of the Providence Fire Department Rescue Squad, and Carl V. Slader of the Providence Chapter, American Red Cross, have aided Chairman Quinn in the formation and execution of the following objectives:

1. Because of specialized training, qualifications and planned coordination, a rescue squad will be better able to and more efficiently serve their community and cooperate with doctors and agencies in time of need.

2. At the scene of disaster, accident or emergency, state and local police and the medical profession will recgnize units or members of units who can present a current Red Cross *Advanced* certificate, wear an approved emblem indicating proper training, or exhibit a badge of identification (see cut).

3. In order to meet this efficient participation objective, *free* courses in Red Cross Standard and Advanced First Aid and all phases of rescue work will be offered by well-known and well-qualified instructors. Certificates will be issued upon satisfactory completion of such a course.

4. The Red Cross will provide instructors for an 18-hour Standard and a 12-hour Advanced First Aid course and offer refresher courses to previously trained men. An Advanced Refresher course is now only eight hours in length and can be conducted over a period of three years.

The Committee owes a debt of gratitude to Drs. George W. Waterman, Frank W. Dimmitt, Ralph D. Richardson, Meyer Saklad, William A. McDonnell, and Samuel Nathans for their unselfish donation of time, and particularly to Dr. McDonnell for his repeated contribution to Volunteer Fire Companies throughout the state.

It is hoped that all physicians will understand, appreciate, and utilize the experience of the fireman and his equipment, for his objective is to do the right thing at the right time until the doctor arrives, and then to step quietly aside, ready and willing to assist when directed. To date 511 firemen have received a standard first aid course certificate and 412 have gone on to complete the advanced rating. Here, then, is the nucleus of First Aid teams in the event of an active Civil Defense program.



The badge shown above indicates that the wearer is a qualified Advanced First Aider. All State and local police will recognize this badge which is loaned by the State Police to the wearer as long as he maintains an active Red Cross Advanced Certificate.

Multiple Vitamin Therapy

". . . Patients fare much better when [the deficiencies] are treated simultaneously. . . . Convalescence is delayed when one gives only one vitamin at a time . . ." (Spies & Butt in Duncan, G. G.: Diseases of Metabolism, ed. 2, Philadelphia, Saunders, 1947, p. 504.)

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SQUIBB

PRIORITIES TO BE OBSERVED IN CALLING MEDICAL AND DENTAL RESERVE OFFICERS TO ACTIVE DUTY

(The following directives have been submitted to the Rhode Island Medical Society by Richard L. Meiling, M.D., Director of Medical Services, Department of Defense, Office of Medical Services, Washington, D. C.)

THE SECRETARY OF DEFENSE
Washington
7 September, 1950

MEMORANDUM FOR THE SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE

Subject: Priorities to be observed in calling medical and dental reserve officers to active duty.

By direction of the President, the military departments will strictly observe the following order of priorities in calling to active duty medical and dental reserve officers who are not members of organized reserve units:

First Priority:

Medical and dental reserve officers who were V-12 or ASTP participants, and who have had no prior military service as commissioned medical or dental officers. It is desired that substantially all this group of officers be called before calls are made to the individuals in the second priority.

Second Priority:

Medical and dental reserve officers who were V-12 or ASTP participants, and who have had prior military service. These individuals will be classified by numbers of months of previous active duty, and will be called in inverse order of the number of months of previous active duty they have to their credit. It is desired that substantially all of this group of officers be called before calls are made to the individuals in the third priority.

Third Priority:

Other reserve officers.

Exceptions:

Exceptions may be made to the above priorities in the case of medical reserve officers who have not yet completed twelve full months of medical internship. These individuals, if actively pursuing a medical internship, will be granted a delay in call-up until they have completed a total of twelve full months.

Additionally, in special cases, where a military department can show a military need for the services of a particular individual or group of individuals with special qualifications whose prior service might otherwise tend to warrant their delay in call-up under the policy enunciated above, exceptions may be made so as to authorize their recall to duty but then only after obtaining the approval of the Director of Medical Services.

Attention is invited to the memorandum of 20 July 1950 addressed to the Secretaries of the military departments by which the military services were authorized to make calls into the Federal service of certain organized units and of individual members of the Reserve. The second paragraph of that memorandum indicated that advance notice to me of the proposed issuance of orders of categories of specialists in the Reserve was required. In keeping with that directive, I desire specific notification of all plans with reference to future calls to be made for all medical and dental officers, and I wish to receive them sufficiently in advance of the proposed publication of orders so that they can be reviewed in my office.

In addition, to the extent that medical and dental reserve officers who are not members of organized reserve units have heretofore been ordered to duty but have not yet reported for duty, in a priority order other than the one set out above, I want the Secretary of each of the military departments to review its procedures in issuing such calls, in order to eliminate inequities to the maximum possible extent.

The Director of Medical Services will request information from the military departments which will permit me to be kept fully informed monthly of the status of all medical and dental personnel called to active duty.

/s/ LOUIS JOHNSON

continued on page 546

TWO ADDED SUGARS

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mounts slightly in excess of th
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Developed to Meet the Needs of the Physician in Infant Feeding



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THE WHITE HOUSE
Washington

September 9, 1950

My dear Mr. Secretary:

I have today approved S. 4029 "To amend the Selective Service Act of 1948, as amended, so as to provide for special registration, classification, and induction of certain medical, dental and allied specialist categories, and for other purposes."

The specific provisions of this Act not only authorize induction of doctors, dentists and related specialist personnel for service in the Armed Forces, but they also establish certain priorities for calling such persons for service. These priorities appear to me to be logical and fair, both to the Government and to the individuals affected.

If, as now seems certain, we shall not be able to meet our needs for doctors and dentists by volunteer service, it is my desire that the same priority of call be established for reserve and nonreserve personnel.

You are hereby directed, within such general policies as may be established for deferment from induction or call to active duty, to order that such persons who received their education at Government expense under the Army specialized training program and the Navy V-12 program will be called first. Any reserve personnel who are not assigned to organized units in high priority for extended active duty as units and who were educated at Government expense, are to be fitted into the established priorities for call on the same basis as nonreserve personnel and regardless of the immediate needs of the individual service in which they may hold reserve commissions. It would obviously be unfair to induct persons of lower priority in the specialist categories when persons in higher categories are available even if inter-service transfer or detail to another service for a temporary period should be required to make the individual specialist involved available.

Sincerely yours,
/s/ HARRY TRUMAN

The Honorable
The Secretary of Defense

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1. Bargen, J. A.: Gastroenterology 13:275, 1949
2. Ivy, A. C., and Berman, A. L.: Minnesota Med. 22:815, 1939

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RHODE ISLAND MEDICAL SOCIETY
October 1, 1950

Where District Society is not listed after the name the Fellow is a member of the Providence Medical Association.

Telephone numbers have been checked with the latest available directories and every effort has been made to insure accuracy.

Any errors in this listing should be reported immediately to the Executive Office of the Society.

A

Abbate, Rocco, (*Kent*) 873 Warwick Avenue, Lakewood — HO 1-3323
Abramson, Lewis, (*Newport*) 280 Broadway, Newport — Newport 5400
Adams, Frank M., 122 Waterman Street, Providence 6 — GA 1-4183
Adelman, Maurice, 209 Angell Street, Providence 6 — DE 1-9129
Adelson, Samuel, (*Newport*) 135 Touro Street, Newport — Newport 784-W
Agnelli, Freeman B., (*Washington*) 25 Elm Street, Westerly — Westerly 2507
Alexander, George H., Butler Hospital, Providence 6 — GA 1-3456
Allen, Reginald A., 223 Thayer Street, Providence 6 — GA 1-5552
Allin, Francis E., 2247 Mineral Spring Avenue, Centerdale 11 — CE 1-0154-W
Anderson, Carl V., (*Kent*) Pondville Hospital, Box 111, Walpole, Massachusetts
Angelone, C. Thomas, 872 Park Avenue, Cranston 10 — HO 1-3900
Angeloni, Tito, 406 Branch Avenue, Providence 4 — DE 1-6676
Archetto, Angelo, 964 Cranston Street, Providence 9 — EL 1-3717
Arciero, Michael, 225 Admiral Street, Providence 8 — GA 1-7330
Arlen, Richard S., 359 Broad Street, Providence 7 — DE 1-8210
Armington, Herbert H., 789 Broad Street, Providence 7 — ST 1-4115
Ashton, George W., (*Woonsocket*) Harrisville — Pascoag 91
Ashworth, Charles J., 184 Angell Street, Providence 6 — GA 1-4370
Astle, Christopher J., 278 Broad Street, Providence 3 — GA 1-3167

B

Badway, Joseph M., 549 Broadway, Providence 9 — UN 1-2400
Baldridge, Robert R., 192 Angell Street, Providence 6 — GA 1-3448
Bandeian, Alice K., (*Pawtucket*) 210 Pine Street, Holyoke, Massachusetts
Bandeian, John J., 203 Angell Street, Providence 6 — GA 1-4624
Barber, Paul E., (*Kent*) 1022 Main Street, West Warwick — VA 1-2500-W
Barnes, Albert E., (*Pawtucket*) 491 Broad Street, Lonsdale — PA 5-1740
Barnes, Alvah H., 451 Plainfield Street, Providence 9 — EL 1-2514
Baronian, Durtad R., 688 Cranston Street, Providence 7 — WI 1-3310
Barr, Kathleen M., 605 Hope Street, Providence 6 — GA 1-4114
Barrett, Harold S., 116 Lakewood Circle South, Manchester, Connecticut
Barrett, John T., 122 Waterman Street, Providence 6 — JA 1-2244
Barry, Ambrose G., (*Pawtucket*) 387 Broadway, Pawtucket — PA 3-4312
Bartley, James H., Jr., 7 Benefit Street, Providence 3 — DE 1-6350
Batchelder, Philip, 129 Waterman Street, Providence 6 — GA 1-2166
Batchelder, Walter E., 1035 Maple Avenue, Dowers Grove, Illinois
Bates, Reuben C., 122 Waterman Street, Providence 6 — GA 1-4233
Baute, Joseph A., (*Kent*) 4547 Post Road, East Greenwich — GR 1-0420W
Beardsley, J. Murray, 154 Waterman Street, Providence 6 — UN 1-1880
Beaudin, Briand N., (*Kent*) 46 West Warwick Avenue, West Warwick — VA 1-0092
Beaudoin, Louis I., (*Pawtucket*) 710 Main Street, Pawtucket — PA 2-7696
Beaudreault, Elphege A., (*Woonsocket*) Mercy Hospital, Hillcrest Drive, San Diego, California
Beck, Irving A., 355 Thayer Street, Providence 6 — UN 1-1452
Beckett, Francis H., 189 Waterman Street, Providence 6 — GA 1-3342
Behrendt, Vera M., State Hospital, Howard — HO 1-3700
Bell, Duncan W. J., 211 Angell Street, Providence 6 — DE 1-0159
Bellino, Antonio, 341 Broadway, Providence 9 — PL 1-2224
Benjamin, Emanuel W., 105 Waterman Street, Providence 6 — JA 1-1441
Bernardo, John R., (*Bristol*) 342 High Street, Bristol — Bristol 319
Bernasconi, Ezio J., 726 Broad Street, Providence 7 — WI 1-3212

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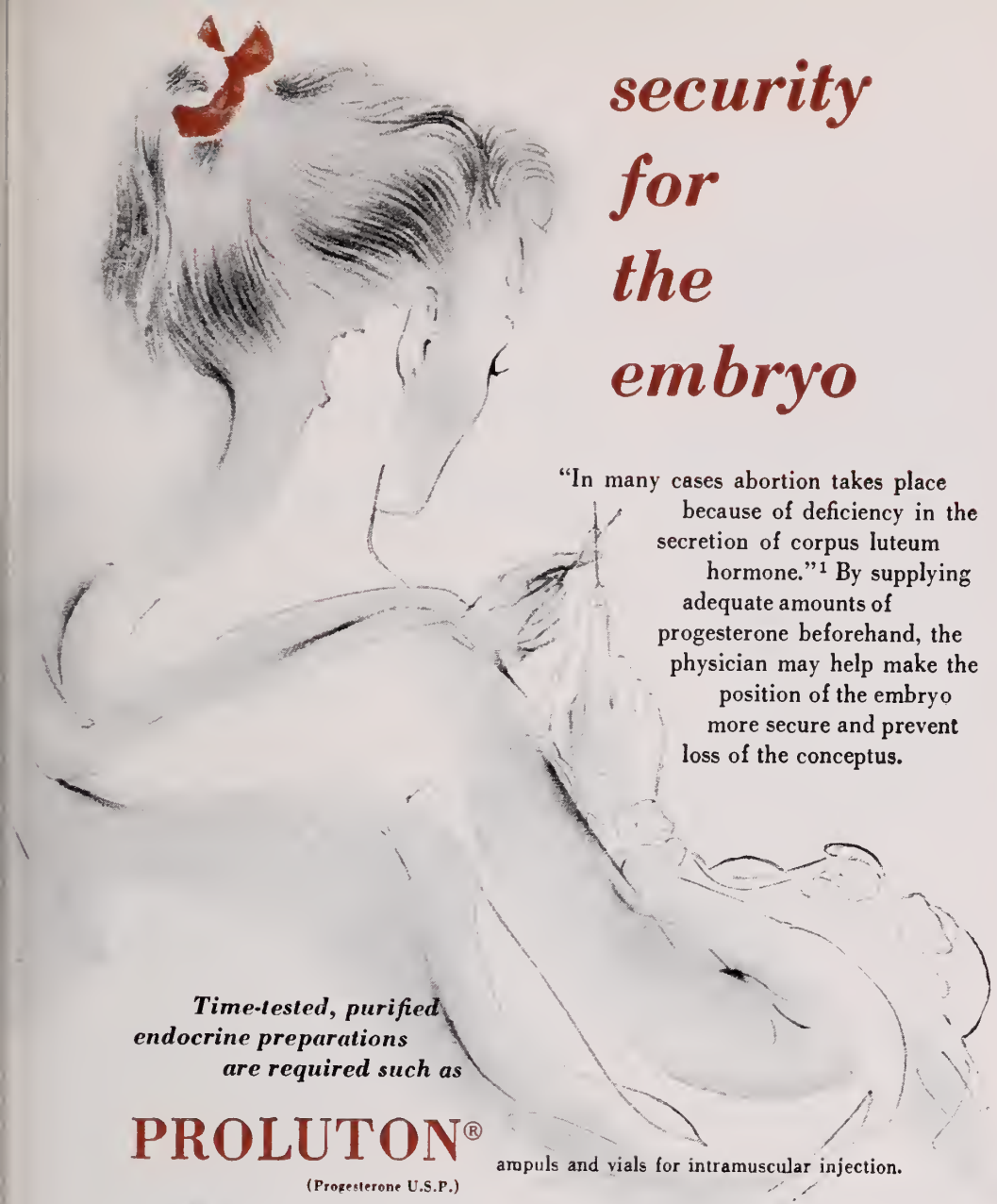
continued from page 548

Bernstein, Perry, 169 Angell Street, Providence 6 — DE 1-5115
Berrillo, Anacleto, 409 Broadway, Providence 9 — UN 1-6611
Bertini, Armando A., (*Pawtucket*) 9 Cottage Street, Pawtucket — PA 5-7329
Bertone, Virgilio M., (*Woonsocket*) 21 Hamlet Avenue, Woonsocket — Woonsocket 2560
Bestoso, Robert L., (*Newport*) 64 Touro Street, Newport — Newport 3036-W
Bird, Clarence E., 116 Waterman Street, Providence 6 — GA 1-6363
Bishop, E. Wade, 182 Waterman Street, Providence 6 — GA 1-2475
Black, Edward J., 169 Angell Street, Providence 6 — DE 1-6059
Blanchard, Howard E., 59 Elmwood Avenue, Providence 7 — GA 1-2622
Blount, Samuel G., 207 Admiral Street, Providence 8 — DE 1-5436
Bolotow, Nathan A., 126 Waterman Street, Providence 6 — PL 1-4987
Bolster, John A., 243 Elmwood Avenue, Providence 7 — DE 1-6270
Botvin, Morris, 155 Angell Street, Providence 6 — UN 1-1210
Boucher, Paul E., (*Woonsocket*) 55 Hamlet Avenue, Woonsocket — Woonsocket 67-W
Boucher, Reginald H., (*Pawtucket*) 704 Main Street, Pawtucket — PA 3-5534
Bourn, Lucy E., 381 Angell Street, Providence 6 — DE 1-1694
Bowen, Earl A., 669 Park Avenue, Cranston 10 — HO 1-4130
Bowles, George E., 154 Waterman Street, Providence 6 — DE 1-1898
Boyd, James F., 195 Angell Street, Providence 6 — GA 1-1589
Brackett, Edward S., 123 Waterman Street, Providence 6 — GA 1-6431
Bradley, Charles, University of Oregon, Portland, Oregon
Bradshaw, Arthur B., 49 Beacon Avenue, Providence 3 — GA 1-3852
Bray, Russell S., 454 Angell Street, Providence 6 — PL 1-2440
Brennen, Earle H., 58 John Street, East Providence 14 — EA 1-0942
Breslin, Robert H., 1494 Broad Street, Providence 5 — HO 1-3113
Brochu, Charles E., (*Woonsocket*) 38 Hamlet Avenue, Woonsocket — Woonsocket 6174
Brothers, John H., 637 Smith Street, Providence 8 — DE 1-4180
Brown, Abe A., 18963 Wisconsin, Detroit 21, Michigan
Brownell, Henry W., (*Newport*) 10 Bull Street, Newport — Newport 512-W
Bruno, Paul C., (*Bristol*) 51 Church Street, Bristol — BR 1-0514
Bruno, Rocco, (*Pawtucket*) 193 East Avenue, Pawtucket — PA 3-4669
Bryan, Charles E., 425 Willett Avenue, Riverside 15 — EA 1-0961-W
Buffum, William P., 122 Waterman Street, Providence 6 — GA 1-3446
Burgess, Alex M., 454 Angell Street, Providence 6 — PL 1-2440
Burgess, Alexander M., Jr., 454 Angell Street, Providence 6 — PL 1-2440
Burke, Edward F., 410 Broadway, Providence 9 — UN 1-5504, JA 1-2331
Burns, Francis L., 382 Broad Street, Providence 7 — DE 1-1164
Burns, Frederic J., 5 Hillside Avenue, Providence 6 — PA 5-1476
Burns, Louis E., (*Newport*) 24 Bull Street, Newport — Newport 39
Burrows, Ernest A., 116 Waterman Street, Providence 6 — GA 1-3636
Burton, Kenneth G., 124 Waterman Street, Providence 6 — GA 1-0473
Butler, William J., 199 Angell Street, Providence 6 — DE 1-0294
Buxton, Bertram, Jr., 167 Angell Street, Providence 6 — GA 1-6431

C

Caldarone, Alfred A., 104 Almy Street, Providence 9 — UN 1-4482
Calder, Harold G., 224 Thayer Street, Providence 6 — GA 1-1947
Calise, Domenico, 441 Broadway, Providence 9 — UN 1-5529
Callahan, James C., (*Newport*) 10 Bull Street, Newport — Newport 171
Cameron, Edward S., 82 Waterman Street, Providence 6 — GA 1-1989
Campbell, Walter E., 224 Thayer Street, Providence 6 — GA 1-2324
Capalbo, Sylvester A., (*Washington*) 75 Woodruff Avenue, Wakefield — Narr. 414
Capobianco, Giovanni, 536 Admiral Street, Providence 8 — GA 1-5819
Capwell, Remington P., 32 Reservoir Avenue, Providence 7 — WI 1-2255
Cardi, Alphonse R., 1303 Cranston Street, Cranston 9 — EL 1-1836
Cardillo, Edward, 463 Broadway, Providence — JA 1-2030
Carey, John E., (*Newport*) 33 Kay Street, Newport — Newport 2121
Carney, Wilfred I., 185 Angell Street, Providence — JA 1-5541
Carroll, Robert E., 295 Angell Street, Providence 6 — GA 1-7377
Case, Jarvis D., 223 Thayer Street, Providence 6 — GA 1-3040
Cashman, Charles W., Jr., 270 Benefit Street, Providence 3 — TE 1-3243
Castronovo, Joseph, 555 Broadway, Providence 9 — UN 1-6363
Catullo, Emilio A., 162 Academy Avenue, Providence 8 — EL 1-6858
Celestino, Pasquale J., (*Washington*) Main Street, Hope Valley — Hope Valley 154
Cella, Louis J., 514 Broadway, Providence 9 — UN 1-3535
Ceppi, Charles B., (*Newport*) 68 Narragansett Avenue, Jamestown — Jamestown 8
Cerrito, Louis C., (*Washington*) 22 Elm Street, Westerly — Westerly 4232
Chace, Robert R., 20 Ridge Road, Bronxville, N. Y.

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Chafee, Francis H., 154 Waterman Street, Providence 6 ..... GA 1-4645
Chapas, Benedict, 341 Smith Street, Providence 8 ..... DE 1-2925
Chapian, Mihran A., 173 Waterman Street, Providence 6 ..... GA 1-0913
Chapman, James G., (*Pawtucket*) 1189 Smithfield Avenue, Saylesville ..... PA 5-7340
Charon, Ernest A., (*Woonsocket*) 105 Coyle Avenue, Pawtucket ..... PA 5-0294
Charon, George E., 924 Atwells Avenue, Providence 9 ..... EL 1-1160
Chase, Peter P., 122 Waterman Street, Providence 6 ..... GA 1-5023
Chaset, Nathan, 105 Keene Street, Providence 6 ..... UN 1-8979
Chesebro, Edmund D., 2 Hawthorne Street, Providence 7 ..... WI 1-1223
Chimento, Dominic, (*Washington*) 9 Granite Street, Westerly ..... Westerly 2306
Cianci, Vincent A., 54 Pocasset Avenue, Providence 9 ..... TE 1-3395
Ciarla, Philomen P., (*Newport*) 105 Pelham Street, Newport ..... Newport 531
Cicma, Haralambie G., 63 Angell Street, Providence 6 ..... GA 1-8485
Cinquegrana, Oswald, 124 Waterman Avenue, East Providence ..... EA 1-4245
Clark, Samuel D., (*Bristol*) 366 Hope Street, Bristol ..... BR 1-0003-W
Clarke, B. Earl, St. Luke's Hospital, New York
Clarke, Elisha D., 109 North Richhill Street, Waynesburg, Pennsylvania
Clarke, Elliott M., (*Pawtucket*) 228 Central Street, Central Falls ..... PA 5-4450
Clarkin, Arthur J., 199 Thayer Street, Providence 6 ..... GA 1-7368
Clune, James P., 156 Auburn Street, Cranston 10 ..... HO 1-1900
Cohen, Earle F., 176 Waterman Street, Providence 6 ..... JA 1-5100
Cohen, Leo, 164 Prairie Avenue, Providence 5 ..... GA 1-3326
Cohen, Paul, (*Woonsocket*) 99 Main Street, Woonsocket ..... Woonsocket 6117-R
Cohen, William B., 105 Waterman Street, Providence 6 ..... GA 1-0843
Colagiovanni, Marco, 288 Broadway, Providence 3 ..... GA 1-5894
Collom, Harold L., (*Kent*) 3235 Post Road, Apponaug ..... HI 1-1214
Conde, George F., 137 Academy Avenue, Providence 8 ..... EL 1-2313
Congdon, Palmer, 454 Angell Street, Providence 6 ..... PL 1-2440
Conlon, Leo V., (*Woonsocket*) 113 Main Street, Woonsocket ..... Woonsocket 2482-W
Connor, Hilary H., Charles V. Chapin Hospital, Providence ..... DE 1-7400
Conrad, E. Victor, 666 Elmgrove Avenue, Providence ..... PL 1-1894
Conte, Alfred C., 540 Charles Street, Providence 4 ..... GA 1-8895
Cook, Paul C., 1451 Broad Street, Providence 5 ..... WI 1-4412
Cooke, Charles O., 167 Power Street, Providence 6 ..... GA 1-3538
Corcione, Mary B., 409 Broadway, Providence 9 ..... JA 1-1787
Cormier, Evariste A., (*Pawtucket*) 1258 Newport Avenue, Pawtucket ..... PA 2-0234
Corrigan, Francis V., 613 Angell Street, Providence 6 ..... GA 1-1347
Corsello, Joseph N., 235 Broadway, Providence 3 ..... EL 1-7066
Corvese, Anthony, 243 Broadway, Providence 3 ..... DE 1-7677
Cox, James H., 141 Waterman Street, Providence 6 ..... GA 1-6336
Crane, G. Edward, 223 Thayer Street, Providence 6 ..... GA 1-5324
Crank, Rawser P., 765 Park Avenue, Cranston 10 ..... WI 1-1614
Crepeau, George A., (*Woonsocket*) 34 Hamlet Avenue, Woonsocket ..... Woonsocket 3102-W
Croce, Gene A., 195 Waterman Street, Providence 6 ..... GA 1-8722
Cronick, Charles H., R. I. State Hospital for Mental Diseases, Howard ..... HO 1-4700
Cuddy, Arthur B., 512 Pontiac Avenue, Cranston 10 ..... WI 1-5249
Cummings, Frank A., 169 Angell Street, Providence 6 ..... DE 1-6622
Curran, Edmund B., Georgetown University Hospital, Washington, D. C.
Curren, L. Addison, 789 Park Avenue, Cranston 10 ..... WI 1-1568
Cutts, Frank B., 154 Waterman Street, Providence 6 ..... GA 1-2664

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Cutts, Katherine K., 9 Irving Avenue, Providence 6 — PL 1-4772
Cutts, Morgan, 154 Waterman Street, Providence 6 — DE 1-3427
Czekanski, Andrew G., (*Pawtucket*) 300 Broad Street, Pawtucket — PA 6-7225

D

Damarjian, Edward, 124 Waterman Street, Providence 6 — GA 1-1808
D'Angelo, Antonio F., (*Bristol*) 99 State Street, Bristol — BR 1-0761
Darrah, Harry E., 42 Woodbury Street, Providence 6 — DE 1-1035
Dashef, Oscar Z., (*Woonsocket*) 202 Stadium Building, Woonsocket — Woonsocket 6011-W
Davies, Stanley D., (*Kent*) 8 St. John Street, West Warwick — VA 1-0961
Davis, George W., 1732 Broad Street, Edgewood 5 — WI 1-2433
Davis, William P., 182 Waterman Street, Providence 6 — DE 1-1536
Deery, James P., 331 State Office Building, Providence 2 — JA 1-7100
DeFusco, Bruno G., 369 Broadway, Providence 9 — UN 1-4509
DeLuca, Joseph, 158 Governor Street, Providence 6 — PL 1-2243
Denhoff, Eric, 187 Waterman Street, Providence 6 — GA 1-1837
DeNyse, Donald L., 922 Park Avenue, Cranston 10 — WI 1-2266
DeStefani, Carlo J., (*Woonsocket*) 689 Wood Avenue, Woonsocket — Woonsocket 6563-W
Devere, Frederick H., 677 Park Avenue, Cranston 10 — HO 1-0242
DeWolf, Halsey, 305 Brook Street, Providence 6 — GA 1-5484
Dileone, Ralph, 223 Broadway, Providence 3 — GA 1-3468
Dillon, John A., 154 Waterman Street, Providence 6 — UN 1-2323
DiMaio, Michael, 415 Angell Street, Providence 6 — JA 1-6682
Dimmitt, Frank W., 78 Waterman Street, Providence 6 — GA 1-2886
DiPippo, Palmino, 1536 Westminster Street, Providence 9 — TE 1-1567
Dolan, Thomas J., 60 South Angell Street, Providence 6 — GA 1-5610
Donley, John E., 222 Broadway, Providence 3 — UN 1-1313
Donnelly, John J., 603 Broad Street, Providence 7 — PL 1-2310
Dotterer, Charles S., (*Newport*) 11 Redwood Street, Newport — Newport 2950
Doucet, Charles S., (*Pawtucket*) 615 Broad Street, Central Falls — PA 5-7041
Dougherty, Edward F., 6374 7th Ave. N., St. Petersburg, Florida
Dowling, Joseph L., 57 Jackson Street, Providence 3 — GA 1-3552
Dowling, Richard H., (*Woonsocket*) 128 Main Street, Woonsocket — Woonsocket 167-W
Drew, Robert W., (*Bristol*) 10 Broad Street, Warren — WA 1-1490-W
Duckworth, Milton, (*Washington*) Carolina — Carolina 17R2
Duffy, Frank P., 372 Pontiac Avenue, Cranston 10 — ST 1-6322
Dufresne, Walter J., (*Pawtucket*) 168 West Avenue, Pawtucket — PA 3-3996
Dugas, Leo, (*Woonsocket*) School Street, Slatersville — Woonsocket 122-W
D'Ugo, William P., 282 Broadway, Providence 3 — GA 1-0151
Dunbar, Charles W., (*Bristol*) 10 Appian Way, W. Barrington 14 — WA 1-1106
Duquette, Leo H., (*Kent*) 1044 Main Street, West Warwick — VA 1-0774
Durkin, Patrick A., (*Pawtucket*) 459 Central Avenue, Pawtucket — PA 2-8263
Durkin, Walter R., 111 Waterman Street, Providence 6 — DE 1-2224
Dustin, Cecil C., R. F. D. 1, Box 151, Rochester, New Hampshire
Dwyer, George J., 796 Atwells Avenue, Providence 9 — TE 1-2615
Dziob, John S., 148 Blackstone Blvd., Providence 6 — DE 1-7360

E

Earley, Charles P., 388 Prairie Avenue, Providence 5 — HO 1-9285
Eckel, Frederick C., (*Washington*) 41 Grove Avenue, Westerly — Westerly 2297
Eckert, George A., (*Newport*) 130 Touro Street, Newport — Newport 35-W
Eckstein, Adolph W., 76 Waterman Street, Providence 6 — GA 1-0767
Eddy, Augustine W., (*Woonsocket*) 42 Hamlet Avenue, Woonsocket — Woonsocket 207-W
Eddy, Jesse P., 3rd, 131 Waterman Street, Providence 6 — PL 1-4044
Eddy, Warren H., (*Woonsocket*) 42 Hamlet Avenue, Woonsocket — Woonsocket 207-W
Egan, Thomas A., 156 Smith Street, Providence 8 — DE 1-9414
Eliot, Alice M. B., Adams Point, Barrington — WA 1-0857
Emidy, H. Lorenzo, (*Woonsocket*) 188 Prospect Street, Woonsocket — Woonsocket 92
Erinakes, Peter C., (*Kent*) 1425 Main Street, West Warwick — VA 1-0896

F

Fagan, James H., 230 Thayer Street, Providence 6 — GA 1-7242
Fain, William, 249 Thayer Street, Providence 6 — GA 1-7271
Falkinburg, LeRoy W., Roger Williams General Hospital, Providence — GA 1-1625
Fallon, James T., Columbus Hospital, Great Falls, Montana
Famiglietti, Edward V., 77 Brown Street, Providence 6 — UN 1-0023
Fanger, Herbert, R. I. Hospital, Providence — DE 1-4300
Farago, Samuel S., (*Washington*) 101 West Broad Street, Westerly — Westerly 2432
Farrell, Charles L., (*Pawtucket*) 166 Pawtucket Avenue, Pawtucket — PA 3-4141
Farrell, George B., (*Kent*) 1018 Main Street, West Warwick — VA 1-0038

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continued from page 554

Farrell, Irving A., (*Pawtucket*) 428 Broad Street, Central Falls	PA 5-3575
Feifer, Anthony M., 547 Broadway, Providence 9	UN 1-3915
Feinberg, Banice, 225 Waterman Street, Providence 6	UN 1-2242
Femino, Richard D., 666 Douglas Avenue, Providence 8	UN 1-1433
Ferguson, Duncan H. C., Jr., (*Pawtucket*) 124 Waterman Street, Providence 6	GA 1-1808
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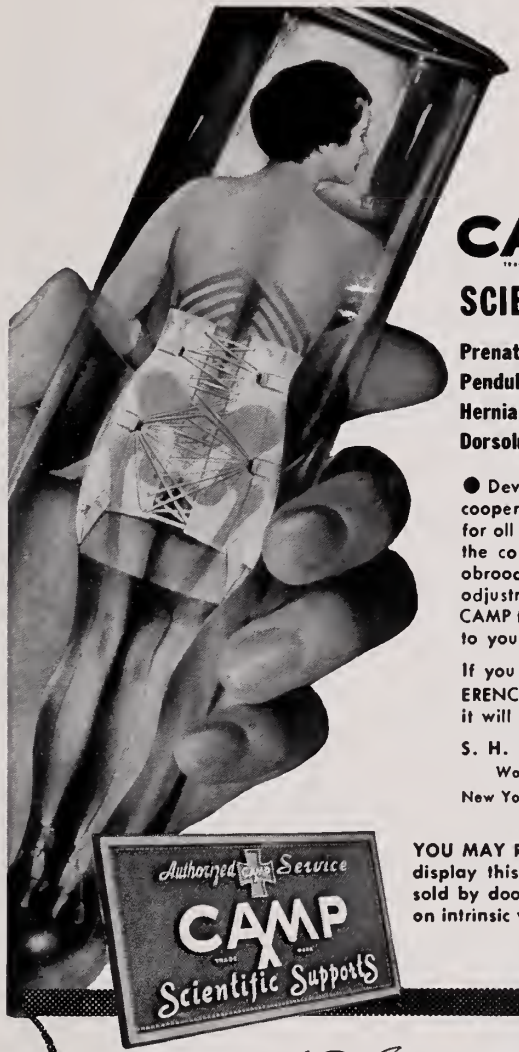
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Porter, Emery M., 454 Angell Street, Providence 6 — PL 1-2440
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Pozzi, Gustave, 209 Waterman Avenue, East Providence 14 — EA 1-0330
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Putnam, Helen C., (*No district society*) 312 Laurel Avenue, Providence 6 — PL 1-4059

Q

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Ryan, Vincent J., 198 Angell Street, Providence 6 GA 1-4313

S

Sage, Louis A., 122 Waterman Street, Providence 6 GA 1-8435
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Saklad, Meyer, 154 Waterman Street, Providence 6 GA 1-0026
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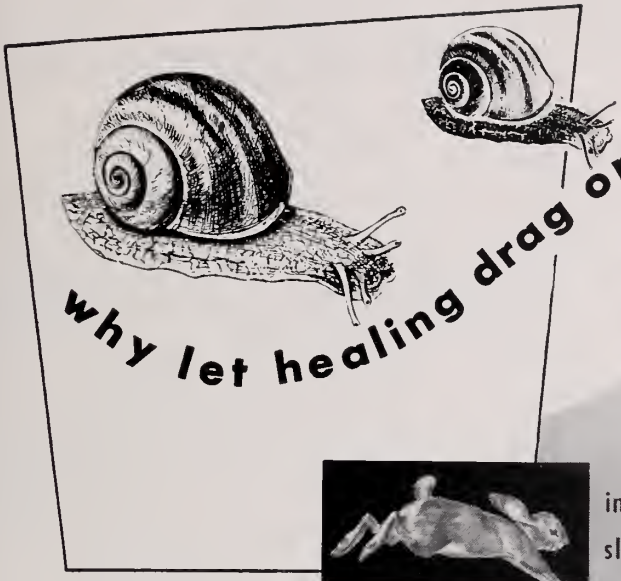
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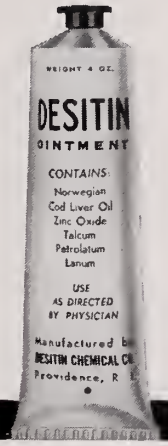
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of *Rhode Island Medical Journal,* published monthly at Providence, Rhode Island, for October, 1950
State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Peter Pineo Chase M.D., who, having been duly sworn according to law, deposes and says that he is the Editor-in-Chief of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily, weekly, semiweekly or triweekly newspaper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Acts of March 3, 1933 and July 2, 1946 (section 537, Postal Laws and Regulations), printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street, Providence 3, R. I.; Managing Editor, John E. Farrell, Sc.D., 106 Francis Street, Providence 3, R. I.

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4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

PETER PINEO CHASE, M.D., *Editor*

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JOHN E. FARRELL
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W

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Waterman, George W., 155 Thayer Street, Providence 6 — DE 1-4229
Webber, Joseph B., 730 Broad Street, Providence 7 — ST 1-5774
Webster, Frederick A., (*Pawtucket*) 131 Waterman Street, Providence 6 — JA 1-4258
Westcott, Clinton S., 454 Angell Street, Providence 6 — PL 1-2440
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Weyler, Henry L. C., 335 Angell Street, Providence 6 — GA 1-0720
Whipple, Richard K., 122 Waterman Street, Providence 6 — DE 1-1700
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Zamil, Edward, (*Newport*) 99 Touro Street, Newport — Newport 6616-W
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Zouraboff, Catherine, 167 Julia Street, Cranston 10 — WI 1-4485
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Zurawski, Charles, 30 Olneyville Square, Providence 9 — JA 1-7611

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[7]Patterson, W. B.: Thrombocytopenic Purpura in Pregnancy and in the Newborn, J. A. M. A. 130:700 (March 16) 1946.

[8]Rushmore, S.: Purpura Complicating Pregnancy, Am. J. Obst. & Gynec. 10:553 (Oct.) 1925.

[9]Pollitzer, S.: Remarks on the Dermatoses of Pregnancy, Am. J. Obst. 53:199 (Jan.) 1906.

[10]Hollander, L., and Vogel, H. R.: More Frequent Skin Diseases Occurring During Pregnancy, Pennsylvania M. J. 48:454 (Feb.) 1945.

[11]Sandler, I. L.: Impetigo Herpetiformis. A Report of a Case and Brief Review of the Literature, Urol. & Cut. Rev. 43:347 (May) 1939.

[12]Downing, J. G., and Jillson, O. F.: Herpes Gestationis; Fetal Anomaly Treated Successfully with Sulfapyridine, New Eng. J. Med. 241:906 (Dec. 8) 1949.

[13]Crawford, G. M., and Leeper, R. W.: Diseases of the Skin in Pregnancy, Arch. Dermat. & Syph. 61:753 (May) 1950.

[14]Mueller, C. W., and Lapp, W. A.: Herpes Gestationis—Report of Two Cases and Survey of Literature, Am. J. Obst. & Gynec. 48:170 (Aug.) 1944.

[15]Weidman, F. D.: In discussion of Elliott, J. A.: Bullous Dermatoses of Toxic Origin. Report of a Case Involving an Association with Choriocarcinoma, Arch. Dermat. & Syph. 37:219 (Feb.) 1938.

[16]Antoine: Cited by Mueller and Lapp[14].

[17]Perrin, C.: Cited by Howard, R. L.: Herpes Gestationis. Report of a Case, Arch. Dermat. & Syph. 28:782 (Dec.) 1933.

[18]Sayer, A.: In discussion of Kampf, M. B.: Herpes Gestationis, Arch. Dermat. & Syph. 42:982 (Nov.) 1940.

[19]Sulzberger, M. B., and Rostenberg, A., Jr.: Practical Procedures in Investigation of Certain Allergic Dermatoses, J. Allergy 6:448 (July) 1935.

[20]Andrews, G. C.: Diseases of the Skin. For Practitioners and Students, ed. 3, Philadelphia, W. B. Saunders Co., 1946, p. 159.

[21]Gross, P.: Erythema Multiforme Gestationis, Arch. Dermat. & Syph. 23:567 (Oct.) 1930.

[22]Kaiser: Cited by Costello[1].

[23]Monash, S.: Proliferative Gingivitis of Pregnancy, Arch. Dermat. & Syph. 24:580 (Oct.) 1931.

[24]Stander, H. J.: Williams Obstetrics. A Textbook for the Use of Students and Practitioners, ed. 8, New York, D. Appleton-Century Co., 1941, p. 580.

[25]Brickner, S. M.: Fibroma Molluscum Gravidarum: A New Clinical Entity, Am. J. Obst. 53:191 (Jan.) 1906.

[26]Templeton, H. J.: Cutaneous Tags of the Neck, Arch. Dermat. & Syph. 33:495 (March) 1936.

[27]Petrini: Cited by Costello[1].

[28]Spitzer, W.: Cited by Costello[1].

[29]Ormsby, O. S., and Montgomery, H.: Diseases of the Skin, ed. 7, Philadelphia, Lea & Febiger, 1948, p. 957.

[30]Beinhauer, L. G.: In discussion of Crawford and Leeper[13].

[31]Kanof, N. B.: Lupus Erythematosus: Physiological Aspects, Arch. Dermat. & Syph. 61:904 (June) 1950.

[32]Ellis, F. A.: In discussion of Crawford and Leeper[13].

[33]Moore, J. E.: Modern Treatment of Syphilis, ed. 2, Springfield, Ill., Charles C. Thomas, 1943, p. 474

[34]Kemp, J. E., and Menninger, W. C.: Influence of Pregnancy on the Course of Syphilis, Brit. J. Ven. Dis. 12:206 (July) 1936.

[35]Thomas, E. W.: Syphilis: Its Course and Management, New York, The Macmillan Co., 1949, pp. 264-266.

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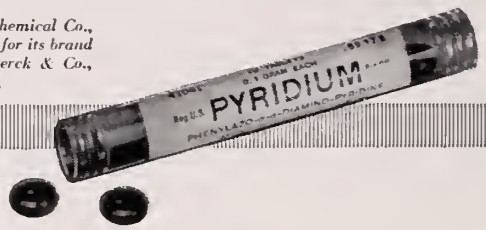
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(*See Page 603*)

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more economical with



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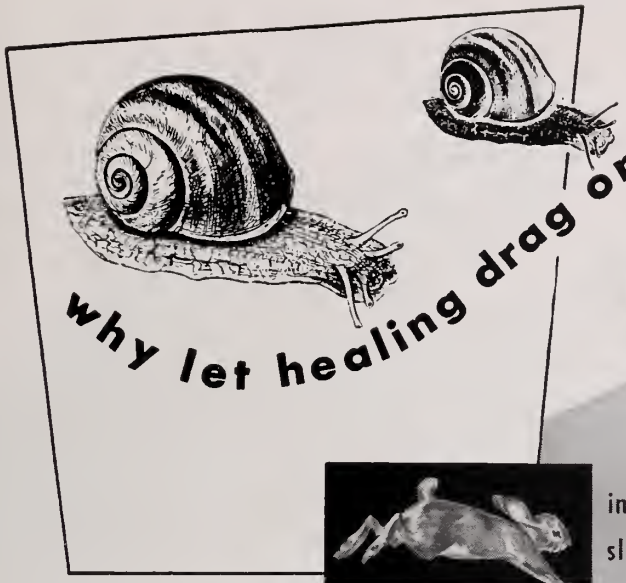
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(1) Thorn, G.W.; Quinby, J.T., and Marshall, C., Jr., Ann. Int. Med. 18:913 (June) 1943.
(2) Orent-Keiles, E., and Hallman, L. F., Circular No. 827, United States Department of Agriculture, Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, Dec., 1949.

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why let healing drag on and on and on . . .

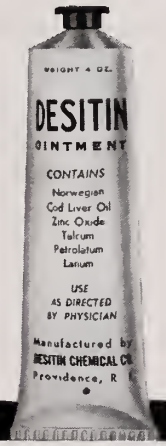
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1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Industrial Med. & Surg. 18:512, 1949.



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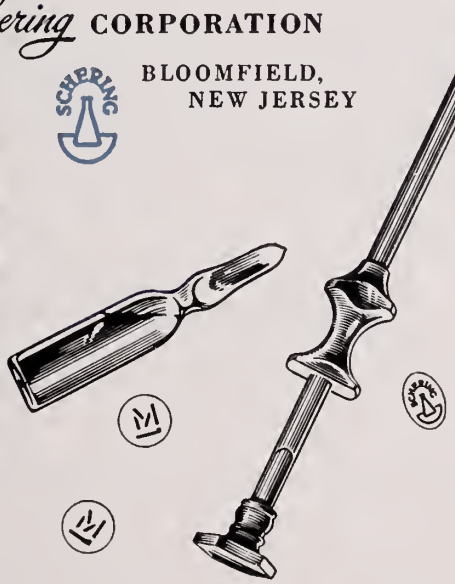
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1. Walker, W.J.: Obesity as a Problem in Preventive Medicine, U.S. Armed Forces M.J. 1:393, 1950.
2. John, H.J.: Dietary Invalidism, Ann. Int. Med. 32:595, 1950.

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Volume XXXIII, No. 11 November, 1950

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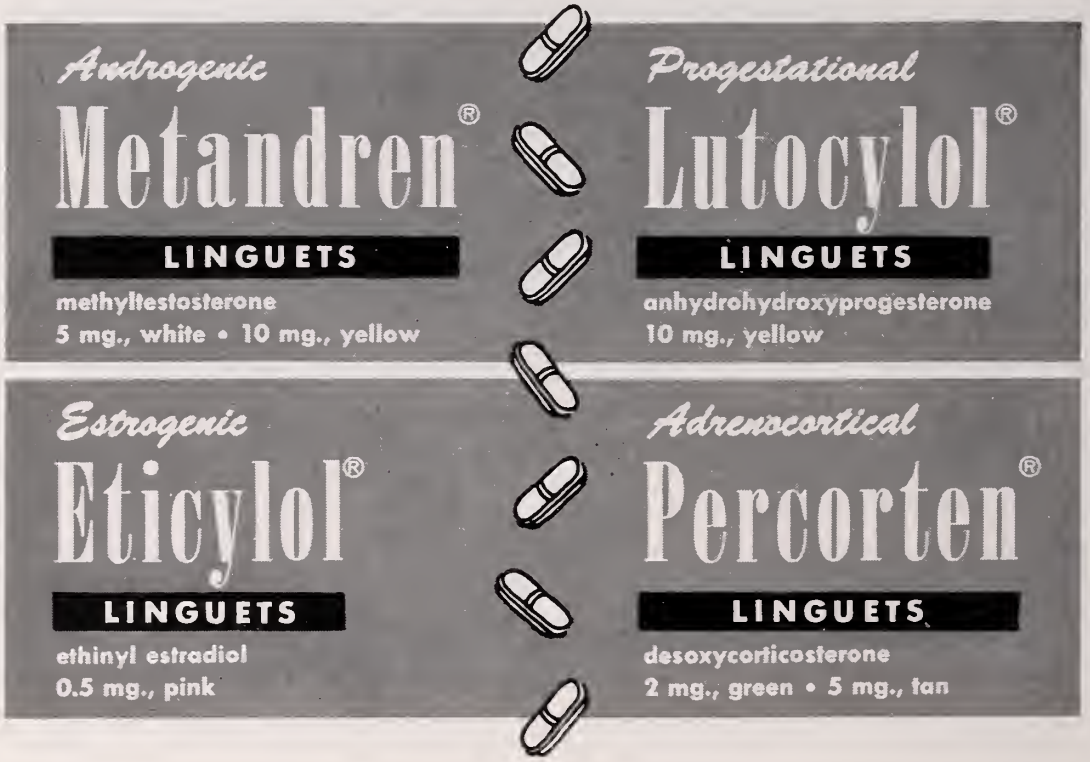
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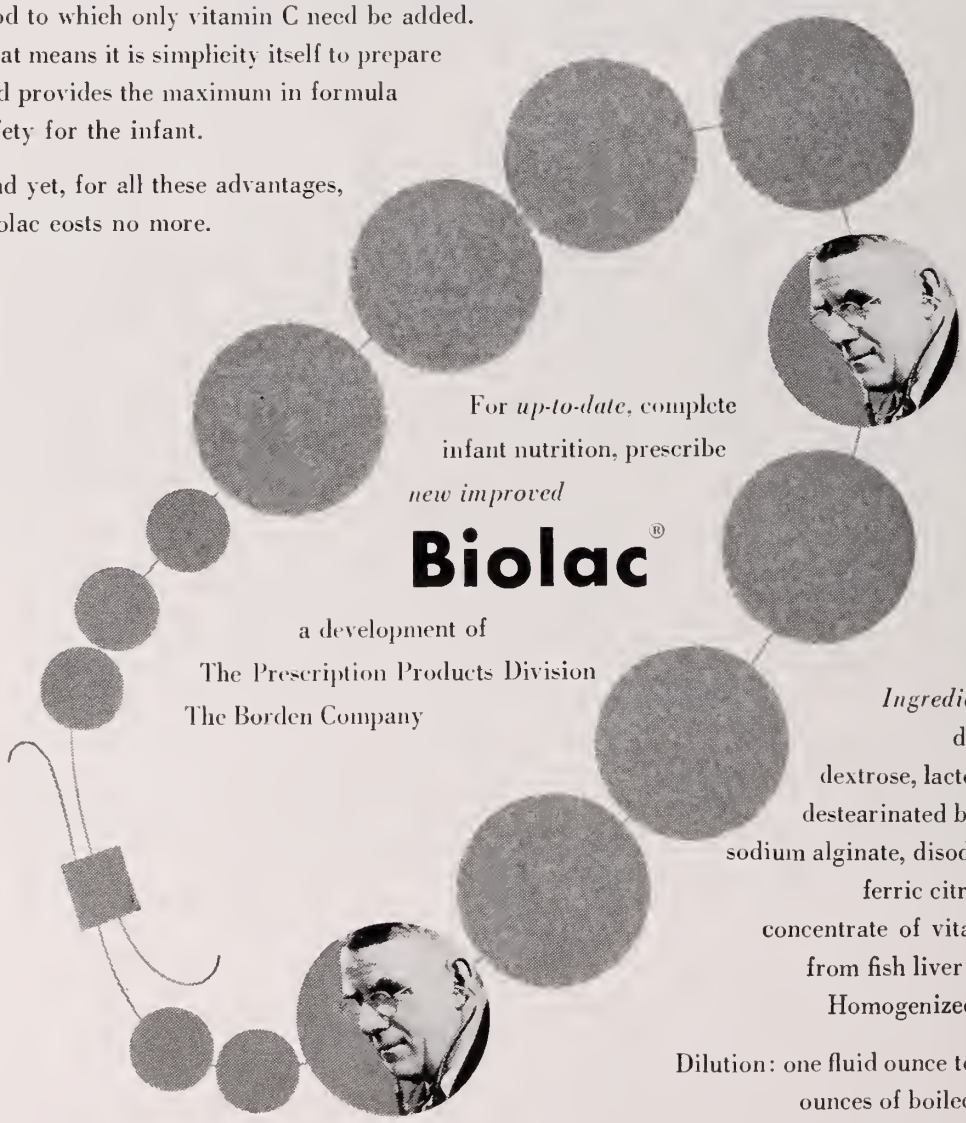
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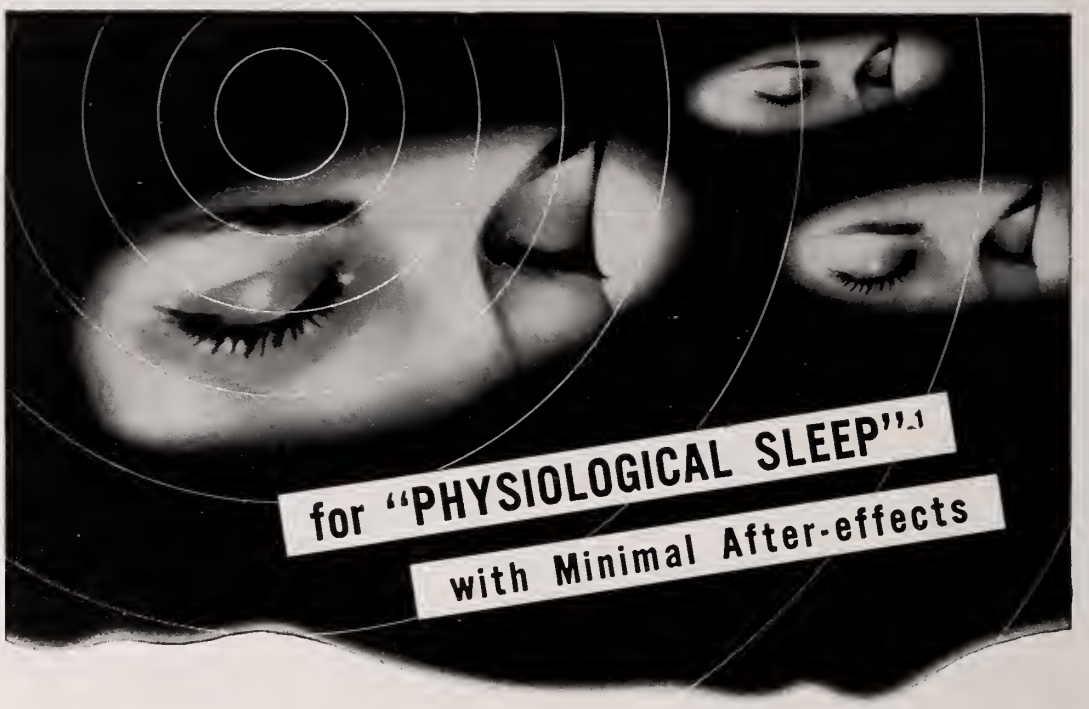
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[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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METASTATIC KRUKENBERG TUMOR OF THE OVARY, PRIMARY IN THE BREAST

With Six Year Survival

HENRY C. MCDUFF, M.D.

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THERE IS EVIDENCE of considerable controversy in the literature concerning the proper definition of Krukenberg tumors of the ovary, and it therefore seems advisable to state our own views. In his original article Krukenberg described the tumor now designated by his name as primary in the ovary, and classified it as a sarcoma, and not an epithelial tumor. His interpretations were later found to be incorrect, but his cellular description remains a classic. While the majority of gynecological and pathological authorities now consider the Krukenberg tumor metastatic, some others disagree. Even among those who concede the metastatic origin of these tumors there is further disagreement regarding the site of the primary neoplasm. Foote[17] in his "Pathology in Surgery" states that it is wrong to call the metastasis from any organ other than the stomach a Krukenberg tumor, and only then when it conforms to the proper microscopic criteria. Ewing also believes that the primary tumor must be in the stomach, but others disagree with these two authorities and contend that any primary gastro-intestinal focus is permissible. Frankl and Lahm writing independently in the German literature have each described typical Krukenberg tumors of the ovary secondary to primary breast foci, but the American literature is almost silent on this particular phase.

The academic understanding of this condition is now even more complex since Novak credits the existence of primary Krukenberg tumors of the ovary, and his contention seems well founded and is now rather generally accepted by those pathologists who allow for the more flexible definition of Krukenberg tumors.

Our concept of Krukenberg tumors is simple, workable, and unhampered by academic disputes. We believe them to be malignant tumors of the ovary, primary, or metastatic from any focus. The ovaries which usually are affected bilaterally, are firm, solid, and moderately enlarged. They generally retain the recognized gross ovarian pattern. The external surface is smooth, and they are usually non-adherent. On cut section they are variegated, and microscopically show the typical mucous containing signet-ring cells with a sarcomatoid stroma.

According to Novak, Krukenberg tumors may spread by the lymphatics, the blood stream, by direct transperitoneal implantation, or by direct tissue continuity. Hundley[8] in referring to secondary carcinoma of the ovary from the breast favors the lymphatic spread with progressive involvement of the breast, the pleura, the sub-pleural lymphatics, and the lumbar glands. These latter glands are in direct association with the ovary. In a series of 59 autopsies for carcinoma of the breast Hundley found ovarian metastases in 5 cases, or 8%, but he failed to mention the type of cell found in the ovary in these cases.

Carcinoma of the breast of the scirrhous or medullary type arises, as do all tumors, from the anaplastic changes involving all cells at once, and not by arithmetical progression from one specific cell. These tumors, unless diagnosed and treated early, tend to metastasize widely to involve a multiplicity of systems and organs. Cheatle and Cutler[4] report that in 423 autopsies for carcinoma of the breast, the ovary was found involved in 8% of the cases and the uterus in 5.7%. The channels of metastases of these tumors are through the lymphatics and the blood stream. Probably the former route through the lumbar glands best accounts for the ovarian involvement, and the hematogenous spread for the involvement of the uterine endometrium.

Robert Meyer[7] points out that in secondary carcinoma of the uterus, regardless of the location of the primary tumor, the ovary is similarly involved in 50% of the cases.

Willis[6] in his text "The Spread of Tumors in the Human Body" favors blood borne metastases

continued on next page

from the breast involving the uterus, and quotes four specific cases from the German literature. Lahm[15] in the fourth volume of Halban and Leitz "Biologie und Pathologie des Weibes" mentions that the outstanding sequence of Krukenberg tumors displays primary involvement of the gastro-intestinal tract, yet he also mentions that primary breast lesions are not rare. Frankl first recorded uterine metastases from the gastro-intestinal tract, and shortly thereafter uterine metastases from carcinoma of the breast. He was uncertain whether the lymphatics or the blood stream served as the principal channel of dissemination from the primary lesion. Novak[5] also mentions that secondary carcinoma of the uterus may come from a gastro-intestinal focus or the breast, but that the ovary is the favorite primary site.

In cases where there is simultaneous involvement of the ovaries and the uterus there is always speculation as to whether the uterus and the ovaries were involved separately or whether, following implantation in one of these secondary sites the extension then progressed to the other. If the latter conjecture is true, then the method of spread revives a long standing controversy. Norris and Vogt[10] favor two way tubal dissemination, and Novak favors lymphogenous metastasis from the uterus to the ovaries. Affutt[14] of the Mayo Clinic in speaking of primary adenocarcinoma of the uterus (which is not under discussion here) points out the infrequency of nodal involvement, and he believes that this is due to the fact that these epithelial cells are too large to be transported by the lymphatics. On the other hand he points out that papillary cyst-adenocarcinoma of the ovary tends to metastasize by direct extension and transplantation, rather than through the blood stream or lymphatics. He reports 520 cases of carcinoma of the uterus with ovarian metastasis in 12%, and 616 cases of adenocarcinoma of the ovary with uterine metastases in 8.6%. He too credits the tube as the chief means of transplantation and metastasis.

Robinson[12], in his reported case of secondary carcinoma of the uterus, tubes, and ovaries from a primary pancreatic focus, favors the retrograde lymphatic spread and continuity, but not transplantation or contiguity.

In Geschickter's[3] text on "Diseases of the Breast" uterine metastases are not mentioned, but he quotes Saphir and Parker as recording ovarian metastases in 8% and 16% respectively.

Taylor[2] and Meigs[1] have both independently reviewed the cases at the New York Memorial Hospital, and the Massachusetts General Hospital respectively, but their reports encompass multiple tumors involving the pelvic organs and the breast, and not metastatic tumors.

Our case displays the typical microscopic and macroscopic findings of a Krukenberg tumor, and the co-existence of similar cells of metastatic origin in the cervix, corpus, and oviducts. Zeigerman[16] has recently reported the rare finding of osteoblastic metastases in a Krukenberg tumor. Our case also exemplifies this feature.

Case Report

A. G., a 44 year old, single, Russian born female, entered the New York Post-Graduate Hospital on May 4, 1948 with the chief complaint of swelling of the abdomen for 4 weeks prior to admission. Her family history was negative, and her past medical and surgical history except as it pertained to her present illness was also non-contributory. Her systemic review was also not relevant in any way to her present illness. Menstruation had been normal and painless from the age of 12, until she was subjected to x-ray castration 1½ years before she came under observation, after which there was no further bleeding. There had been 3 pregnancies, all terminated by induced abortion, the last 15 years previously, with no subsequent sepsis.

Present Illness: In 1943, 5 years before admission, the patient had consulted a physician because of a hard mass in the upper outer quadrant of the right breast which dimpled the overlying skin. A right radical mastectomy with axillary dissection was done in another hospital and she was discharged on the 14th post-operative day. Following discharge she was given the usual x-ray therapy; 1800 r to inferior and direct axilla, and 200 r to the posterior axilla, over a period of 16 days, ending April 28, 1943.

Following this the patient did well without evidence of metastases or local recurrence until 1945, a period of two years. At that time she developed a right pleural effusion and symptoms of intercostal neuritis. The aspirated fluid was negative both for malignant cells and tuberculosis. X-rays at this time revealed the presence of metastatic lesions of osteoblastic density in the neck of the left scapula, and she was given another course of radio-therapy. The last treatment was given in June of 1946, and roentgenograms 2 months later showed marked decrease of the metastatic foci.

In October 1946, 3½ years after her mastectomy, she was given radiation therapy for a mass of skin metastases over the anterior chest wall, and the right parietal region of the head. Because of these recurrent lesions, the patient was given a castrating dose of x-ray to her ovaries. (600 r over anterior and posterior pelvis). In addition to this she was started on a course of testosterone therapy, 100 mgms three times a week for 2 months, with a 2 months rest period between. She had received 4 such courses before her hospitalization at the Post-

Graduate. Under male hormone therapy the patient felt greatly relieved, and continued in relatively good health until 6 weeks before admission. At this time she complained of distention of the abdomen, pain in her hips, and progressive shortness of breath. She was told by many physicians that it was nothing but gas and would pass off. Finally a diagnosis of an ovarian tumor was made and she was admitted to the Post-Graduate Hospital for laparotomy.

Physical Examination: The patient was a well developed and well nourished 44 year old female, manifesting a moderate dyspnoea, she appeared drawn and chronically ill.

T—100 P—76 R—26 BP—138/60

Head: Small firm raised nodule 2x4 cm. over right parietal area.

Neck: No stiffness, trachea in midline, thyroid not felt, no lymphadenopathy.

Chest: Bony cage symmetrical, few scattered small raised nodules over sternum. *Lungs:* Clear to P and A, no rales or ronchi. *Heart:* Normal except for a constant soft systolic murmur. *Breasts:* Right breast had been surgically removed, modified Stewart incision. There was a small 4x5 cm. scar at the mesial end of the wound, the site of previous x-ray therapy. The left breast was soft, pendulous, not tender, and contained no masses. The right axilla was invaded by the operative scar, but the arm motion was normal with but minimal edema.

Abdomen: No scars, tenderness, or masses were evident. The skin of the abdominal wall was tense and glistening due to the tremendous distention of the entire abdomen. Fluid wave and shifting dullness were easily elicited.

Back: The spine revealed moderate thoracic kyphosis. No vertebral or costo-vertebral angle tenderness.

Pelvic Exam: External genitalia were normal. Marital introitus. Anterior and posterior walls well supported. The cervix was small, clean and well epithelialized. Moderate whitish yellow discharge. No distinct pelvic, adnexal, or abdominal masses could be outlined because of the extensive intra-abdominal distention, but the lower margin of a large pelvic tumor was palpable in the posterior vaginal fornix.

Rectal: Sphincter action good, no hemorrhoids.

Extremities: Normal, no limitation of motion. Reflexes normal.

Impression on admission: Ovarian tumor with acites.

Progress in Hospital: Her blood count and urinanalysis were normal, and her blood chemistry was likewise normal except for a low serum Protein. On the day following admission patient was operated on under cyclopropane, ether, curare anesthesia. She received 500 c.c. of blood during the procedure. On opening the abdomen there was a considerable quantity of free fluid in the peritoneal cavity which was evacuated by suction. The uterus was large and soft, and contained numerous nodular fibroids. The ovaries were both enlarged and stony hard, and adherent deep in the cul-de-sac. On the left side the ovary was firmly adherent to the sigmoid. The liver, omentum, and peritoneal surfaces were free from evidence of metastasis. A low supracervical hysterectomy and bilateral salpingo-oophorectomy was done.

Her post-operative course was entirely normal, temperature never exceeding 100.6. She was discharged from the hospital symptomatically improved on the 12th post-operative day, after her first x-ray treatment to the pelvis. During this hospitalization she complained intermittently of pain in her left hip, and this was successfully treated with testosterone.

Pathological Diagnosis:

1) Secondary Ca (signet-ring type) of uterus and cervix following carcinoma of the breast.
2) Secondary Ca of fallopian tubes (signet-ring type), following carcinoma of the breast.
3) Secondary Ca of right and left ovary (Krukenberg type), following carcinoma of the breast.
4) Leiomyoma of the uterus.
5) Adenomyosis of uterus.

Pathological Findings: (Dr. Thomas G. Morrione, Asst. Professor Pathology, University Hospital, New York University).

Sections of the original breast tumor (fig. 1) show solid cords of anaplastic tumor cells supported by a moderately abundant fibrous stroma. Occasional tumor cells show signet-ring appearance.

Macroscopic Examination: The uterus, a supracervical specimen, measured 8x8x5 cm. and contained numerous leiomyomata. The largest of these measures 7 cm. in diameter. The endometrial cavity is distorted and lined by intact endometrium.

The ovaries are both considerably enlarged, the right measuring 5x4x3 cm., and the left 6x5x4 cm. They present a similar appearance with pinkish or red multinodular external surfaces. They show a rubbery consistency and the cut surfaces are glistening white with multiple yellowish areas.

continued on next page

The Fallopian tubes are not unusual save for increased consistency throughout.

Microscopic Examination: Metastatic tumor cells are present in large numbers in the endometrium, myometrium, both ovaries and the Fallopian tubes. (figs. 2, 3, 4). The tumor cells are large with hyperchromatic nuclei and acidophilic cytoplasm. Many tumor cells show cytoplasmic vacuolization, and some show a typical signet-ring appearance.

Her abdomen again became tremendously distended with fluid, and she was readmitted to the hospital for paracentesis three weeks after her original discharge. During this time she was given large doses of methyl testosterone to control her extensive bony metastases, and under this therapy she developed a hair growth on her upper lip.

When readmitted on June 11th the physical findings were as previously described except that her abdomen was tensely distended with fluid, and

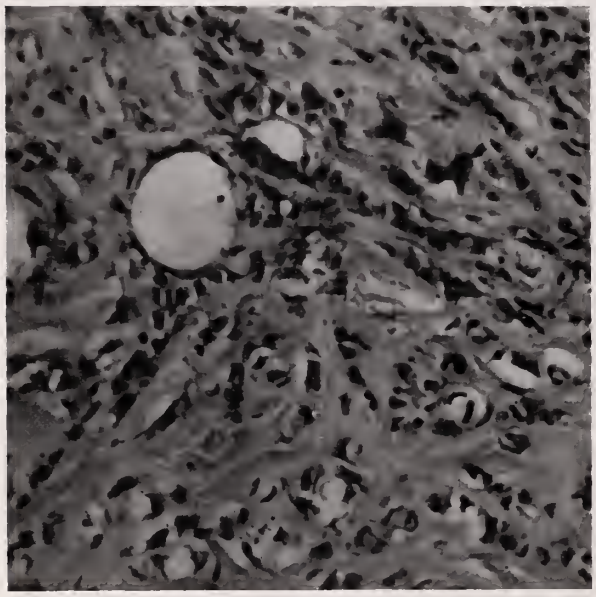


Figure 1: Photomicrograph of primary carcinoma in the breast showing signet-ring forms.

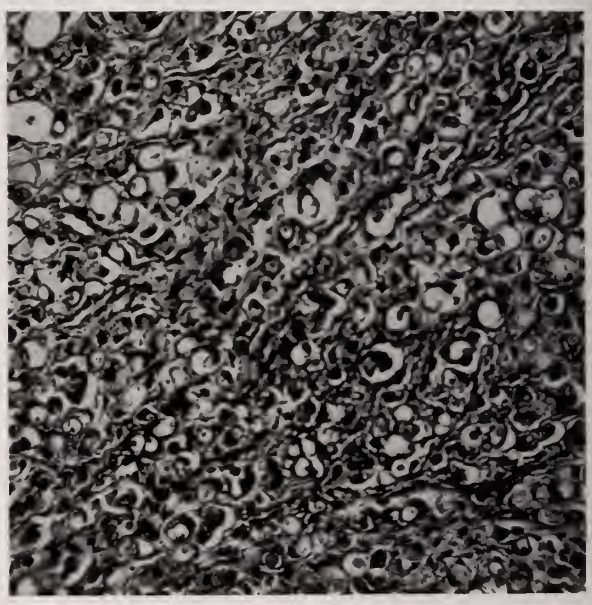


Figure 2: Photomicrograph of right ovary showing Krukenberg tumor. Multitudes of signet-ring cells lie in a sarcomatoid stroma.

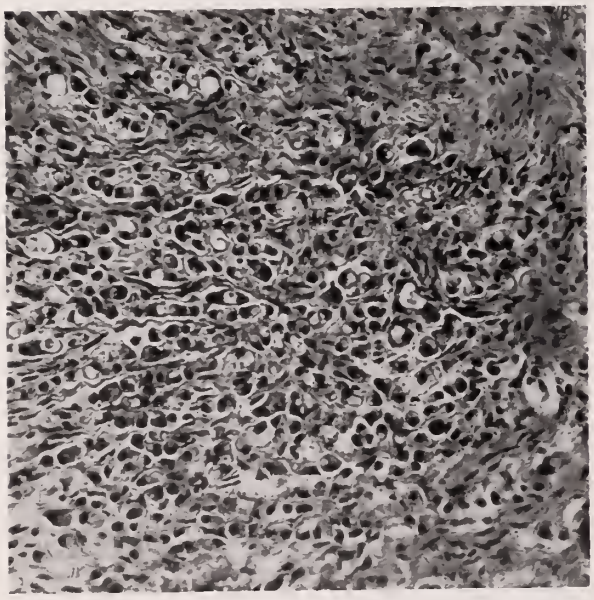


Figure 3: Photomicrograph of left ovary showing Krukenberg tumor, and illustrating the diffuse infiltration by vacuolated and signet-ring type tumor cells.

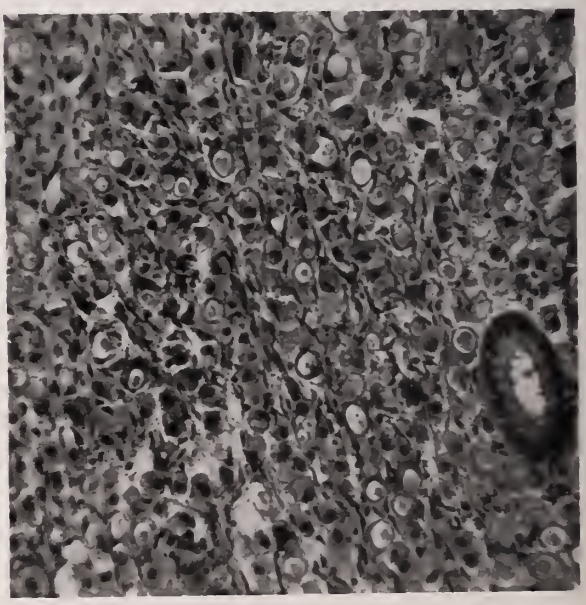


Figure 4: Photomicrograph of myometrium of uterus showing metastatic tumor. Here again the tumor cells show abundant cytoplasmic accumulation of mucin. The solitary gland is of endometrial origin indicating an incidental associated adenomyosis.

the skin of the lower abdomen about the operative incision showed a marked follicular reaction due to the x-ray therapy. Her chest plate revealed no evidence of parenchymal metastases, though pleural thickening was prominent. The films of the pelvis, upper femora, and lumbar spine, (figs. 5, 6) showed extensive osteoblastic metastases and a pathological compression fracture of the second lumbar vertebra.

Blood count showed a moderate anemia.



Figure 5: Film of pelvis and upper femora showing multiple osteoblastic metastases involving the entire pelvis and upper femora.



Figure 6: Film of the lower dorsal and lumbar spine showing pathological compression fracture of the 2nd lumbar vertebra.

On the day following readmission a paracentesis was done with recovery of 2700 c.c. of smoky amber fluid. Protein content of this fluid was 1.9 mgms. %, sp. gr. was 1.024. Specimens of this fluid were examined in both the pathology and cytology laboratories. Both reports mentioned the finding of gland-like cellular structures with numerous mucous-containing signet-ring cells showing macronuclei, and macronucleoli. She was discharged improved three days later to resume her x-ray treatments.

Sixteen days later she was readmitted again because of nausea, vomiting, and intermittent daily fever. Her physical examination at this time again revealed a tensely distended abdomen, with signs of intraperitoneal fluid. The afternoon of admission another paracentesis was done with recovery of 3000 cc. of amber colored fluid. This was not sent for pathological study because it was felt that nothing additional could be added to the diagnosis.

Her temperature rose to 105° following the paracentesis but a blood culture taken at height of chill was sterile. Throughout her 13 days hospitalization her temperature fluctuated with a mid-afternoon spike to 102°-103°. She was given penicillin, and with lack of response, streptomycin, which likewise caused no change in her temperature course. On the day following paracentesis the patient complained of severe pain at the site of the puncture, and examination of the wound revealed the area to be tender, reddened, and indurated. Hot compresses were applied with some relief. Nausea and vomiting began on the third hospital day and was so severe that a Levine tube was passed and she was maintained on parenteral fluids and vitamins. On the sixth hospital day the nausea subsided and the tube was removed. About this time the drainage from the paracentesis wound became definitely fecal in nature and the extruded material was characteristic of a small bowel fistula. She was discharged improved on the 13th hospital day with the fistula still draining.

On the 22nd of July a gastrointestinal series was done which was entirely normal, and on the 28th of July a barium enema was done which also was normal. At the time the second x-ray was taken the fistula had closed spontaneously, and the patient looked and felt greatly improved. This patient is now apparently enjoying excellent health and is free from symptoms.

A vaginal smear taken 1 year following her operation showed only an atrophic menopause. Her post-operative interval is now 17 months, and 6 years have passed since the mastectomy. When last seen she was in good health complaining only of intermittent back pain.

Summary

We have presented a brief review of the literature concerning the definition of Krukenberg tumors and their possible routes of metastasis. We have defined our concept of Krukenberg tumors, and pre-

concluded on page 630

SERUM PROTEIN, CEPHALIN FLOCCULATION, AND THYMOL TURBIDITY ALTERATIONS IN LUPUS ERYTHEMATOSUS DISSEMINATUS

— *A Case Report* —

ROBERT V. LEWIS, M.D. and LOUIS I. KRAMER, M.D.

The Authors, *Robert V. Lewis, M.D.*, Haffenreffer Research Fellow in Internal Medicine, 1947-1948; Louis I. Kramer, M.D., Physician, Department of Medicine, Rhode Island Hospital.*

Introduction

According to preliminary reports,[22] the prognosis of Lupus Erythematosus Disseminatus, when treated with A. C. T. H. or Cortisone, may be regarded as more hopeful. The diagnosis of this disease clinically is extremely difficult, especially in the absence of the typical skin lesions and with predominantly urinary signs.

Since the original preparation of this paper, the findings of alterations in the cephalin flocculation and thymol turbidity reactions in two more cases of Lupus Erythematosus Disseminatus have been observed. In both the unreported cases the most striking changes were in the kidneys, and both had absent skin lesions. The diagnosis of polycystic kidney disease was first made clinically in both cases. Subsequently, these unreported cases proved to be Lupus Erythematosus Disseminatus. In both these cases the findings of markedly altered serum proteins and abnormal cephalin flocculation and thymol turbidity reactions were of great value in establishing the diagnosis and the commencement of A.C.T.H. therapy.

History

Alterations in the serum protein in lupus erythematosus disseminata have been described by many authors. Teilum[1] has recently reviewed this finding and postulated its mechanism. Coburn and Moore[2] and Thyresson[3] have reported on the increased globulins in the disease. Thorn[4] and Rothman and Felsher[5] have demonstrated the electrophoretic changes which are essentially a decrease in albumin and increase in the gamma-globulins. Rothman and Krupa[6] showed a slightly elevated A_2 with a lowered albumin, but without change in the other fractions. Omens and Omens[7] report a case with no gross change in the globulins. Keil[8] states that there is a tendency for globulin increase but it is not striking. Brenner[9] reports a case where the globulin was low. A summary of twenty cases reported by Klemperer[10] shows three cases only where the total globulin concentration was above three grams percent. The alterations in the serum proteins may result in false positive tests for syphilis. White[11] has reviewed the literature and concludes it may occur but is rare. When this occurs it is due to hyperglobulinemia as shown by Neurath.[12]

Alterations in the serum proteins in lupus erythematosus do occur and they are reduction in albumin coincident with albuminuria and increase in the gamma-globulins. Baehr[13] states that the albuminuria can equal that of the nephrotic syndrome. Brenner[9] reports just such a case. However, both the albuminuria and the increase in gamma-globulins are not constant features. Furthermore, there is little in the literature concerning the time features in the development of the changes.

A case is here reported in which the development of the serum globulin change was observed along with interesting changes in the cephalin flocculation and thymol turbidity which reflected alterations in the composition of the globulin.

Methods

The thymol turbidity reaction was determined according to Maclagan[14]. The cephalin flocculation as directed by Hanger[21]. The albumin globulin separation was done by the Howe 22% sodium sulfate method. Protein concentrations were determined by the Bowman sulfo-salicylic acid method.[15]

Case Report

The patient, a 31-year-old white female, entered Rhode Island Hospital on May 10, 1948, for complaints which originated four months earlier in February, 1948. The chief complaint in February, 1948, was facial edema and facial rash. A diagnosis of angioneurotic edema was made and the patient was referred by the physician to a dermatologist. The edema and rash failed to improve and new symptoms of fatigue and malaise appeared. These symptoms were followed by sore throat and mouth. Recurrent chilly sensations and non-productive cough were noted by the patient. Lesions in the

*This paper was prepared while the author was Haffenreffer Research Fellow in Internal Medicine at the Rhode Island Hospital.

mouth increased and interfered with eating. A month after the first symptom, the patient was hospitalized at a neighboring hospital. At that time, the following physical signs were noted: Edema and rash on face, gingivitis, pharyngitis, edema and ulceration of the lips, petechiae on both legs. Temperature, 100-103; blood pressure, 130/80.

Laboratory Studies Prior to Admission

Blood counts	Red blood count	3.5 million
	White blood count	5,000 plus
	Differential	Lymphs predominate
	Platelets	Reduced
Blood Chemistry	P.S.P.	75% of normal
	Urea nitrogen	Normal
	Cholesterol	Slightly elevated
Urine Chemistry	Protein	3+
	Granular casts	1+
Tests	Tourniquet	Negative
	B.M.R.	—6

During March and April until admission to Rhode Island Hospital on May 10, 1948, the patient received the following therapy: Salt poor diet; concentrated protein supplements; iron; multiple vitamins; penicillin, two million units; penicillin troches; penicillin spray. The mouth lesions subsided and recurred in a cyclic manner.

On May 10, 1948, the patient entered the Rhode Island Hospital where the following physical examination was recorded:

Temperature, 101; pulse, 108; respiration, 24; blood pressure, 110/75. Patient is a fairly well-developed, well-nourished white woman who appears chronically ill.

Face: The face is swollen and covered with a brownish, finely pigmented, scaly rash extending to the ears where the scales are more extensive. There are a few circumscribed lesions beneath the ears, (Figure 1).

Eyes: Retinal examination shows waxy exudates around the right disc and along some of the major vessels. In the left fundus there are exudates similar to the right fundus. A fresh superficial hemorrhage is seen at the disc margin between two and four o'clock.

Mouth: Lips are dry and cracked. There are ulcerations along the gums and exudates in the pharynx.

Chest: Lungs normal to percussion. Auscultation revealed presence of rales over entire chest posteriorly.

Heart: Negative.



Fig. 1



Fig. 2

Abdomen: Distended. Liver palpable, not tender, two finger-breadths below costal border. Spleen not palpable.

Skin: (See Face). The skin over the entire body is coarse, dry, scaly. There are old petechiae in the region of the ankle bilaterally. Erythema and telangiectasis on dorsum of terminal phalanges of feet and at base of toenails (Figure 2).

Lymphnodes: Not abnormal in number or size. Cervical nodes tender.

continued on next page

Laboratory Data:

Blood			
Red blood count	2.9 million		
Hemoglobin	9.4 grams		
White blood count	3,100		
Differential	41% lymphocytes		
Urea nitrogen	13	14	
Glucose			
Protein	5.8	6.0	7.0
Albumin	2.5	2.4	2.8
Globulin	3.3	3.6	4.2
Thymol turbidity	28	35	45
Cephalin flocculation		4+	4+
Cholesterol	298		
Urine			
Specific Gravity	1.003	1.010	
Reaction	6	5	
Protein	2+		
Sugar	Negative		
Hyaline	+		
R.B.C.	few		

Chest X-ray

Negative lung field; Cardiac outline normal. (On admission).

Sedimentation Rate

64 in 60 minutes.

Electrocardiogram

Regular rhythm; rate 102; conduction time normal (upper limit) low voltage.

Bacteriology

Smear of mouth lesions showed moderate number gram positive diplococci, few in chains, an occasional fusiform rod. Moderate number diphtheroid rods and an occasional gram negative Neisseria.

Predominating organisms: Hemolytic staphylococcus aureus, streptococcus ciridans, Neisseria.

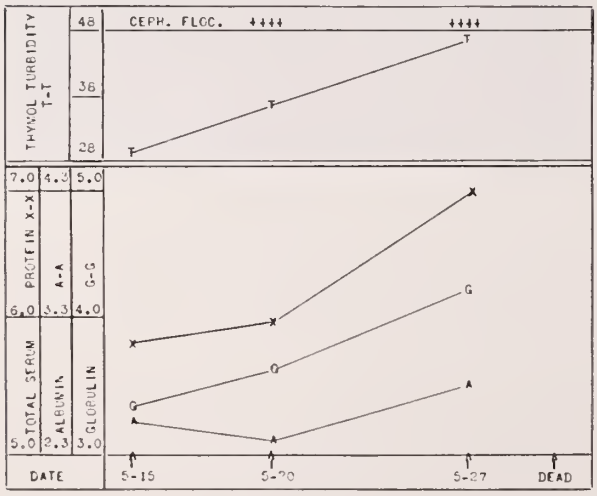


FIG. 3

Illustration of the simultaneous changes in globulin, total protein, and thymol turbidity with increasing severity of the disease.

Laboratory Studies Prior to Admission
Hospital Course

Treatment consisted of three transfusions; iron; low salt, high protein, high vitamin diet. Temperature varied between 99° and 101°, pulse 80 and 120. The patient continually became weaker, developed jaundice and ascites, and died twenty days after admission. A postmortem was not obtained. The history of insidious onset with weakness, fatigue and fever; the characteristic facial rash; the eyeground findings; the renal involvement; the leukopenia and the anemia, made the diagnosis obvious.

Observations

During the two weeks immediately prior to death, marked changes in the blood proteins occurred. The total serum protein increased from 5.8 to 7.0 grams percent. This rise was due to steadily increasing globulin concentrations. The globulin increase was accompanied by a consistently four plus cephalin cholesterol flocculation and an excessively high thymol turbidity reaction which increased from 28 to 45, Table 1 and figure 3.

TABLE I

Relation of Serum Proteins And Qualitative Tests

Date	TSP	Alb.	Glob.	Thymol Turbidity	Cephalin Flocculation
5/15/48	5.8	2.5	3.3	28	Not Done
5/20/48	6.0	2.4	3.6	35	++++
5/27/48	7.0	2.8	4.2	45	++++
5/30/48	Died				

During the hospital course, the urine continually contained protein three and four plus. A 24-hour collection of urine revealed 6.6 grams of protein in the urine per day. The albumin concentration of the blood ranged from 2.4 to 2.8 grams percent, consistent with the urine protein loss.

Discussion

Although the changes in the blood proteins seen in this case have been described, clear-cut examples of the changes are difficult to find. The early drop in total serum protein and albumin may be due to abnormal protein loss. The daily loss of 6.6 grams in the urine is entirely comparable to the 24-hour loss in acute and chronic glomerulonephritis. That a reduction in albumin formation occurs in addition is by no means excluded.

The changes in the globulin fraction in this case are more marked than those usually recorded. Of note is the fact that the rise in globulin paralleled the decline of the patient. It calls forth speculation that in some cases without globulin increase the globulin determinations were made too early in the

natural history of the disease. That such a globulin increase is of poor prognostic value was true in this case and should be looked for in others to confirm or deny the observation. In this case, the globulin concentration was not only elevated but rose with the disease course.

It is generally recognized that the cephalin flocculation is dependent on qualitative and quantitative changes in the globulin fraction of the serum proteins. It is further generally considered to be influenced by gamma-globulins.[16] The findings in this case of completely positive cephalin flocculation reactions indicate gamma-globulin increases.

The thymol turbidity reactions are considered to be influenced by beta-globulin increases.[16, 17] The value in this case was the highest in the experience of Rhode Island Hospital laboratory where over 5,000 determinations have been made.

The mechanism of globulin increase in this patient is purely speculative. Globulin increase is seen with chronic infective processes, notably tuberculosis, syphilis, and kala-azar; also in diseases of the liver, especially Laennec's cirrhosis. Although the liver was palpable, such a finding is very common in Lupus Erythematosus Disseminatus, and is usually due to mild fatty infiltration.[10] Other liver findings which are altered in Lupus Erythematosus Disseminatus are reduced prothrombin times. In general, however, the liver changes in this disease are slight.

The relationship of globulins to lymphocytes[18, 19, 20] and the disturbance in lymphocytes and lymphatic tissue in Lupus Erythematosus Disseminatus is suggestive. In the future an attempt should be made to correlate globulin changes in this disease with alteration in the lymphatic tissue, especially the lymphocytes and plasma cells.

This case well illustrates the blood protein changes that occur in Lupus Erythematosus Disseminatus, which protein changes affect the thymol turbidity and cephalin flocculation tests.

Although more investigation is necessary to establish these findings unequivocably, it would be well to consider the use of these laboratory studies in all cases of suspected Lupus Erythematosus Disseminatus. These studies would be most valuable in cases of Lupus Erythematosus Disseminatus with kidney findings, since unreported studies by one of us (R.V.L.) demonstrate that the thymol turbidity and cephalin flocculation are not grossly abnormal in cases of acute, sub-acute, and chronic glomerulonephritis. Hence, the cephalin flocculation, thymol turbidity, and globulin changes serve to differentiate Lupus Erythematosus Disseminatus from these diseases.

Summary

1. A case of Lupus Erythematosus Disseminatus is presented.
2. The abnormal serum protein concentrations are discussed.
3. The abnormal cephalin flocculation and thymol turbidity were related to altered protein concentration in the reported case.
4. Because of the increasing availability of A.C.T.H. and cortisone and the possibility of effective treatment of Lupus Erythematosus Disseminatus with these compounds, a greater search for early cases of this disease should be made, and the cephalin cholesterol flocculation, thymol turbidity, and globulin changes will help in diagnosing these cases.

Bibliography

[1] Teilum, Am. J. Path., 24, 409, 1948.
[2] Coburn & Moore, Bull. Johns Hopkins Hosp., 73, 196, 1943.
[3] Thyresson, Svenska, Lak.-Tidning, 41, 2315, 1944.
[4] Thorn, J. Clin. Invest., 24, 202, 1945.
[5] Rothman & Felsher, M. Clin., North America 31:198, Jan. 1947.
[6] Rothman & Krupa, Arch. Derm. & Syph., 57, 451, 1948.
[7] Omens & Omens, Arch. Derm. & Syph., 57, 442, 1948.
[8] Keil, Ann. Int. Med., 16: pp. 828, 1942.
[9] Brenner, et al; Am. J. Med. 5:288, 1948.
[10] Klemperer, Arch. Path., 32, 569, 1941.
[11] White, Am. J. Syph., Gonor., & Ven. Dis., 31, 235, 1947.
[12] Neurath, Am. J. Syph., Gonor., & Ven. Dis., 31, 347, 1947.
[13] Baehr, Cecil Text Book of Medicine, 6th edition. Phil., Saunders, 1943, pp. 457.
[14] Maclagan, N. F., Nature, 154, 670, Nov. 1944.
[15] Bowman, J. Lab. & Clin. Med., 21, 1092, 1936.
[16] Recant, et al., Proc. Soc. Exper. Biol. & Med., 60, 245, 1945.
[17] Cohen & Thompson, J. Lab. & Clin. Med., 32, 475, 1947.
[18] Dougherty, et al, Proc. Soc. Exp. Biol. & Med., 57, 295, 1944.
[19] Dougherty, Proc. Soc. Exp. Biol. & Med., 56, 28, 1944.
[20] Harris, et al, J. Exper. Med. 81: 73, 1945.
[21] Hanger, F. M., Tr. Am. A. Physicians, 53, 148, 1938.
[22] Wilson, D. Laurence; Department of Medicine, Peter Bent Brigham Hospital, Boston, Mass. *Remarks:* Medical Conference, Rhode Island Hospital, July 15, 1950.

PHYSICIAN'S EQUIPMENT

FOR SALE. Desk and chair; patient's chair; 3 office chairs; Hamilton suite, including examining table and treatment table with sterilizer; physician's scale; Burdick heat lamp; microscope; instruments and accessories.

CALL UNION 1-0247

(Mrs. Robert L. Farrell)

USE OF TESTOSTERONE IN BREAST TUMOR*

A Case Report

WILLIAM J. SCHWAB, M.D.

The Author, *William J. Schwab, M.D., of Providence, Visiting Gynecologist, and Assistant Secretary of the Tumor Clinic, St. Joseph's Hospital, Providence.*

THIS is the report of Miss A. D., aged sixty-three, first seen at the St. Joseph's Hospital Tumor Clinic, August 4, 1946, for a mass in the right breast. It was described as being a large ulcerative lesion in the lower right quadrant of the right breast, measuring 10.0 cm. in diameter, fixed to the skin and chest wall and causing nipple contraction. It was ulcerated over the entire surface. There was no pain, no discharge, and no eczema. The right axillary and supraclavicular nodes were involved. There was x-ray evidence of other metastases, and the opposite breast was not involved.

It was the opinion of the Tumor Clinic that this case was inoperable. Because of the extensive involvement it was concluded that a course of deep x-ray therapy was the treatment of choice and the patient showed satisfactory improvement for such an advanced disease. A course of therapy was repeated in December, 1946. Twice a year, through January, 1949, this woman received courses of deep x-ray, a total of 16,000 r units to the breast, and 10,000 r units to the nodes in the mid chest. It should be noted that in June, 1949, clinical signs of metastasis other than strictly adjacent to the right breast, that is the skin and the axillary glands, first appeared in the left axilla. As late as November, 1949, there was no evidence of skeletal or chest involvement. By November, 1949, the right breast had become so involved with ulceration, sloughing, and inflammation, that x-ray was out of the question. Penicillin injections were given for treatment of the superimposed infection. Further treatment was deemed useless, and x-ray dangerous. This patient then fulfilled all the criteria for use of hormones in carcinoma: "When all other means are exhausted hormone therapy may be tried."

It was decided to institute a course of Testosterone Therapy. Experience at this time was beginning to advise heavy dosage, and following the writing of Nathanson and others, and improvising our own variations, the patient was started off on an original dose of 200 mg. She was to be followed by a daily dose of 100 mg until a total of 2100 mg had been given, unless toxic signs, or symptoms of masculinity set in. The chief signs of toxicity are those of heart failure: dyspnea, edema, and lung congestion.

The treatment was started 1/13/50. After 400 mg patient was brought into the Accident Room complaining of low backache, leg pain, and dyspnea. She was very weak and showed the early signs of cardiac insufficiency associated with hormone toxicity. All treatment was stopped for ten days. The only difference noted in the breast after inception of treatment was that the mass in the breast seemed softer. The fact that some liquefaction might be occurring was justification enough for ordering resumption of treatment. However, it was decided to give the Testosterone in 100 mg doses only three times a week over a period of six weeks until the cycle of 2100 mg was completed. She was warned to report of any signs of toxicity. On 2/24/50 patient reported in with edema of hands and feet, and low back pains. She was sent to Medical Clinic for an evaluation and an opinion as to the advisability of continuation of treatment. Their conclusion was to allow treatment to continue. Also, at this time, evidence of metastatic disease was found for the first time in the right humeral and right femoral heads on x-ray examination.

On 3/31/50 patient completed course of 2,000 mg of Testosterone. Evaluation showed evidence of liquefaction of the mass in the right breast, part of the broken down area had sclerosed and, generally, showed signs of clearing. The left breast felt softer. X-ray showed recalcification of the right humeral head but no change in the right femoral head. She had no signs of hirsutism or voice changes. Extension of treatment at rate of 200 mg a week for five more weeks was advised.

Examination on 5/12/50, the patient now having received 3,000 mg of Testosterone, showed that the right breast had one small open surface one-half centimeter in diameter which was clean. The entire breast which was riddled with carcinoma showed liquefactive changes. The tissue was soft with no well defined borders to any mass. The

* Presented at the Monthly Meeting of the St. Joseph's Hospital Staff Association, May 16, 1950.

right axilla was clean. The left breast had a resistance below the nipple but no deep or superficial attachment. The nipple was not retracted. There was a gland in the left axilla the size of an English walnut which was mobile. X-ray of the right humeral head showed continued calcification. X-ray of the right femur showed a slight amount of recalcification and no further progression of the metastases since the last x-ray. The patient's voice was deeper and all about the mouth was a slight, but definite growth of hair. Subjectively she stated she felt much better and that she could walk more comfortably. The patient had improved considerably. Where there was a woman with a fetid discharging breast, thoroughly discouraged at the onset of the treatment, there was now one with a sense of well being and a feeling of security. She is to be carried on a maintenance dose of 50 mg of Testosterone twice weekly.

The use of androgens in the treatment of breast carcinoma is relatively new. In "The Medical Clinics of North America" of January 1948, Dr. Frank E. Adair, Associate Professor of Clinical Surgery, Cornell University Medical School, Attending Surgeon, Memorial Hospital, New York City, reviews the literature, and establishes that A. A. Loesser was the first to note the effects of Testosterone on breast cancer in 1939. He established that in two cases of breast cancer, which had recurred in the scar and supraclavicular nodes, that Testosterone, in moderate doses given to relieve menorrhagia, caused the metastases to clear up for a period of 21 months. Loesser theorized that the node of action of male hormone may be explained as a "neutralization" of estrogen (endocrinological castration).

It has been fairly well established that Testosterone has a profound effect on Carcinoma of the Breast and nearly as great on bony metastasis. Soft tissue metastasis may respond occasionally, but usually the results are disappointing. As to chest and liver metastasis the review of the literature is so discouraging as to question the value of using the drug. One definite point has been proven: the dosage must be large, perhaps even larger than used in the case discussed, and a maintenance dose would seem imperative. There is a possibility that this maintenance dose could be maintained orally. In every case I have reviewed, I have come to the conclusion that if the hormonal therapy is ever stopped, and the disease becomes active, repeat course of therapy is useless. This would lead one to conclude, possibly, that the hormone acts as a deterrent and actual inhibitor when steadily used, but loses this power if at any time interrupted.

The initial favorable response of the lesions to the hormones is possibly due to depression by the androgen of the gonadotropic function of the pituitary gland which results in a suppression of ovarian estrogen production; and subsequently the function of elaborating estrogenic hormones is taken over by the adrenals which are not influenced by the administration of androgens.

Testosterone may be said to have two effects:

1. The direct—Regression of the primary tumor and its metastatic nodules. (May have occurred in the case presented).

2. The indirect—The sclerosis produced in the metastatic bone lesions and the osseous system as a whole. The improvement is due to the laying down of osteoblasts and the processes of bone repair. Incidentally improvement is much more striking in bone metastasis than in soft tissue recurrence. Unfortunately, as in the case described, it happens frequently that with two bony lesions, the humeral head, and the femoral head, under the same influence, one may heal, and the other may increase, and apparently not be influenced.

Summary

1. A case has been presented that has apparently been considerably alleviated by the use of male hormone. The original disease in the breast shows evidence not only of arrest but also of recession. Bony metastatic changes show recession rapid in the humerus, slow in the femur.

2. A brief review of the literature on hormonal therapy in carcinoma of the breast has been presented in the abstract.

3. Dosage of the androgens should be radical, rather than conservative, and at present it would appear that maintenance dosage is far superior to courses of therapy.

4. There is no adequate substitute for early diagnosis and surgery. The use of hormones instead of surgery is to be condemned. Hormone therapy at this time is strictly the court of last resort.

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DECEMBER 13 . . .

Midwinter Meeting at Woonsocket

The RHODE ISLAND MEDICAL JOURNAL

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MINORITY SPOKESMEN

WE WISH our opponents in our fight against bureaucratic medicine were not so tough. Take Mr. Oscar Ewing in his recent speech when he accused the American Medical Association of Jew baiting—this to an organization which has been spearheaded for years by Dr. Morris Fishbein. He was anathema to Mr. Ewing and all his associates. It was only after these people, by their tremendous propaganda, had convinced the public that Morris Fishbein was wicked, that the AMA were finally forced to remove him from his office as Editor of the Journal.

Mr. Ewing is a politician and everything is fair in war, love, and politics. Dr. Allen Butler, we don't imagine has political aspirations. He probably is content to be an able pediatrician. Probably he has no wish to hold a Government job when the bureaucratic state finally swallows up medicine. But anyone who has heard him discuss even medical problems knows that he has berserk zeal, and when he discusses the iniquities of his fellow doctors, he just runs out of bounds.

A woman, who we are sure wished to listen with an unprejudiced mind to the arguments pro and con about Government insurance, told us that Dr. Butler was "terrible" when he came down to Providence a year or so ago to discuss this matter. He accused one of our best informed doctors of quoting figures that didn't exist in one of his arguments. When this doctor produced the printed statistics which he had quoted, Dr. Butler made no acknowledgment. He is in sharp contrast to Dr. Channing Frothingham who is fully as zealous in the same cause as Dr. Butler, but nevertheless always conducts himself in a courteous manner.

One of our friends, Dr. James Howard Means, irritates us with his article, *The Doctors' Lobby* in the last *Atlantic Monthly*. All of us physicians in Providence admire Dr. Means greatly. He is a brilliant man, who has held the exalted position of Professor of Medicine at Harvard since a few years after graduation from the medical school. He was at our Annual Meeting last May, where his talk on the Thyroid Gland was a highlight. We are sure all the doctors who met him personally found him delightful.

Nevertheless, nobody likes to be scorned. In this article he heaps the scorn on us who are waging a battle against bureaucratic medicine. He feels badly that we are "portraying the horrors of government medicine." He dislikes that we should put political pressure on politicians that they may vote right on medical bills. His scorn is great that we have a campaign emblem of "a mediocre Victorian painting displaying an ill child or maybe a dead one," and that "public places have been as be-plastered with this chestnut as with the advertisements of a popular tooth paste."

Of course, a very small proportion of the voters of the U.S.A. would have access to the Isabella Stuart Gardner Museum of Boston, whose art is undoubtedly on a much higher plane than that of

the Tait Gallery of London, and few of them if they got there, would have the appreciation that Dr. Means possesses. It is a common human trait to idealize. In our heart of hearts we doctors know that few of us are like the lovely Scotch doctor BESIDE THE BONNIE BRIAR BUSH, or like Dr. John Brown of Biggar. But after all it's a forgivable thing that we should picture ourselves in this way.

When the speaker of the AMA House of Delegates rejoices over the defeat of some of the medical bills before Congress, this is only "Dr. Borzell's bombast." Dr. Means is disturbed because "the methods of coercion open to organized medicine include expulsion from membership." Those are big words to use because a voluntary association drops from membership those who do not pay their dues. We wonder how many labor organizations retain in their membership those who are delinquent.

Dr. Means says he is no Socialist, but he feels that where there are financial difficulties, the obvious solution is to accept Government funds to help out. It is hard for us to believe that he does not know that when Government bureaus furnish the money, they always demand the control. In advocating partial financial support from the Government, isn't Dr. Means like the young woman who rejoiced that she was only a little bit pregnant? We think that if Dr. Means and the young woman were farsighted they would know the ultimate results.

CONVALESCENT HOMES

We have received recently a memorandum with this pertinent remark: "One of the greatest dangers in socialized medicine, of course, is that doctors would be subject to intolerable dictation from bureaucratic officials under any system of Government medicine." A recent reading of the newspapers in our fair city of Providence should cause us to pause and ponder this statement.

We are told that the Building Inspector has recently notified all nursing homes within the city that they would be closed and refused licenses for 1951 should they fail to be of brick structure above the first floor. There can be hardly any convalescent homes in Providence at the present time that can meet such a qualification. Hence, this would mean that in about two months practically all the convalescent homes in the city would have to close, unless they can procure for themselves in that time brick buildings properly equipped for their work.

This, of course, is a preposterous way to conduct a reform if it is necessary. We have been told that it is twenty-seven years since the city of Providence received from the legislature authority to enact a building law ordinance. From time to time the City Council has appropriated money for this work. No report of the context or any part of such an ordinance has been made to the Council or publicly related.

The question immediately arises as to what may be the authority of the Building Inspector. Possibly the courts might decide that he was acting without any foundation of authority. Possibly he knows what the public certainly does not know, that there will be such a building law ordinance passed by the City Government. It might even well be that if the City Government passed such an ordinance that the courts would hold it discriminatory.

There probably are in this big city, in which the residences are almost all of wood, large numbers of elderly and ill persons housed above the first floor in wooden frame buildings. We would judge that there are many more such persons under the care of families at home than are in convalescent homes.

These arguments may sound good to the keepers of convalescent homes, but how many of them would dare to flaunt the Building Inspector on the hopes that the courts would, in the due and slow process of law, back them up? If these people are really given an ultimatum on January 1st, to close or move into brick buildings, we fear that the city will be without convalescent homes.

Presumably, the Building Inspector would say that the idea back of this sudden movement is the danger of fire. Is this a grave danger which will be removed by his action? For many years nearly all the private surgery in Providence was done in wooden buildings. Through all these years the convalescent homes have been run in wooden buildings. During these years there have been numerous large fires in brick and stone buildings and some of these have caused loss of lives.

We cannot recall any serious injury to people caused by fire in wooden hospitals or convalescent homes of this city. In such places there are persons always up and about day and night. If the Building Inspector really closes these institutions at short notice this will have to result in many invalids remaining at home. We cannot see how this is going to improve the health and safety of our city.

continued on next page

MIDWINTER MEETING

THE midwinter meeting of the Society, to be held at Woonsocket on Wednesday, December 13, has already been widely publicized to the membership.

The meeting this year certainly warrants a large attendance in view of the international crises which have again reached into our medical family in Rhode Island to take some of our members back into military service, and have also alerted all of us again to the necessity of home defense on a scale never before anticipated.

The medical aspects of atomic damages represent a story with which we are only vaguely familiar. The Woonsocket meeting will bring into focus again the latest development in atomic radiation, from the viewpoint of the physician who must be prepared to render medical treatment because of it. The significance of the new civil defense programs, and the whole scheme of disaster planning for our communities requires an alerted medical profession.

And aside from the problems of war, the meeting will present to Rhode Island physicians the Erie, Pennsylvania doctor whose name has become one of the most well known during the past year because of the report on hospitals and professional relations prepared by the committee he headed—Dr. Elmer Hess. The recent proposal of the American Hospital Association to take over the classification done now by the American College of Surgeons is indicative of the need for some sound thinking at local levels on the jurisdiction and supervision of medical services in the hospital, and the redefining of the scope of hospital services.

Taken in its entirety the Woonsocket meeting promises to be one of the finest interim sessions ever held by the Society. The committee on arrangements is to be commended for its work, but the finest approval by the membership would be a capacity attendance.

INDUSTRIAL MEDICAL SERVICES

IN THIS ISSUE of the JOURNAL appears the legislation enacted by the General Assembly this year relative to the administration of first aid and/or other medical services in places of employment. Every physician undertaking any industrial health work within the state should familiarize himself with this new law.

Effective next July first, every firm employing 25 or more persons, must provide for the administration of first aid to any employee injured or becoming ill on their premises, designating in the plant one or more employed persons qualified as first aid workers or as practical or registered nurses. The first aiders must qualify under the Red Cross training program.

Those plants employing 400 or more persons are required under this law to set aside and equip on the premises a special accident room or similar accommodation which must be under the direction of a registered nurse. All such nurses are to be under the supervision of a licensed physician and are subject to his standing orders.

The committee on industrial health of the Society has already polled the membership to inquire of physicians whether they are interested in handling industrial work on a part time basis. With the compilation of this list the committee is in a position to assist the industrial and mercantile concerns of the state. In addition, the committee has initiated active work on nurse education for industry, and it will work closely with the division of industrial inspection in the department of labor to assist in making the new law a definite forward step in industrial health in Rhode Island.

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THE GOOD DEEDS OF MEN SURVIVING THEM, OFTEN UNHERALDED AND UNSUNG, ARE FAR NOBLER MEMORIALS THAN THOSE CONTRIVED BY MAN. HIS MEMORIAL IS THE THOUSANDS OF PEOPLE WHO HAVE ESCAPED THE RAVAGES OF TUBERCULOSIS. WITH A DEEP SENSE OF GRATITUDE FOR HAVING KNOWN AND WORKED WITH HIM WE PAUSE TO HONOR HIS MEMORY.

"HIS LIFE WAS GENTLE, AND THE ELEMENTS
SO MIX'D IN HIM THAT NATURE
MIGHT STAND UP
AND SAY TO ALL THE WORLD: THIS WAS A MAN."
. . . *Shakespeare*

The inscription above is from the Zambarano Memorial Plaque unveiled at the Rhode Island State Sanatorium, Wallum Lake, R. I., on October 12, 1950.

RHODE ISLAND DERMATOLOGICAL SOCIETY

The second regular meeting of the Rhode Island Dermatological Society was held on September 20, 1950 at the Wayland Manor.

The meeting was called to order by the president, Dr. F. Ronchese, and on a motion from the floor the reading of the minutes of the last meeting was omitted. The constitution and by-laws, as presented by the Council, was unanimously approved and adopted. The following physicians were elected honorary members: Dr. Anthony C. Cipollaro, professor of Dermatology and Syphilology at New York Polyclinic, New York City; Dr. John G. Downing, professor of Dermatology and Syphilology at Tufts Medical School and Boston University, Boston, Mass., and Dr. Roswell S. Wilcox, of Providence.

The next regular meeting will take place on November 13, 1950. Cases will be presented at the Skin Out-Patient Department, Rhode Island Hospital, starting at 10:00 a. m., and the conference and dinner will be held at the Wayland Manor for members and invited guests at 6:00 p. m. Dr. William B. Cohen will be host.

Respectfully submitted,
BENCEL L. SCHIFF, M.D., *Secretary*

Wednesday, December 13

Midwinter Meeting

of the

RHODE MEDICAL SOCIETY

at the

BLACKSTONE HOTEL

WOONSOCKET

4:00 P. M.

"RADIATION SYNDROME"

ERNEST K. LANDSTEINER, M.D. of Providence

and

JOSEPH W. HOWLAND, M.D.
of Rochester, N. Y.

"PATHOLOGY OF IONIZING RADIATION"

LT. COMDR. RUSSELL MAYNARD, MC, USN,
of Newport Naval Hospital

6:30 P. M. . . . Dinner meeting

Speaker: ELMER HESS, M.D. of Erie, Pa.

"HOSPITAL — PHYSICIAN RELATIONS"

HOUSE OF DELEGATES OF THE RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on September 27, 1950

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, September 27, 1950. The following were in attendance:

Kent
Rocco Abbate, M.D.

Newport
Donald R. Fletcher, M.D.
Frank Logler, M.D.

Pawtucket
Robert Henry, M.D.
Charles L. Farrell, M.D.
(Delegate to the American Medical Association)

Providence
Robert Baldridge, M.D.
J. Murray Beardsley, M.D.
Frank B. Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
David Freedman, M.D.
Herman P. Grossman, M.D.
William Horan, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D.

Providence cont'd.
Ed. A. McLaughlin, M.D.
Joseph C. O'Connell, M.D.
Edwin B. O'Reilly, M.D.
Alfred L. Potter, M.D.
Louis Sage, M.D.

Washington
Samuel Nathans, M.D.

Officers:
Charles J. Ashworth, M.D., President
Morgan Cutts, M.D., Secretary
Earl F. Kelly, M.D., Treasurer

Non-delegates in attendance
Orland Smith, M.D.
Edwin Vieira, M.D.
Stanley Sprague, M.D.
John E. Farrell, Sc.D., Executive Secretary

Communications

The Secretary read a communication from the Pawtucket Medical Association relative to the fees approved by the House of Delegates for examinations for life insurance companies. The communication was placed on file.

Report of the Secretary

The report of the Secretary which had been mimeographed and distributed to the members of the House was read by Dr. Morgan Cutts as follows:

"Since the May meeting of the House of Delegates the Council has held two regular meetings and one special meeting. Major actions of the Council taken at these meetings is briefly reported below, and recommendations to the House of Delegates are listed separately:

Public Relations

Reviewed propaganda booklet issued by the Democratic National Committee regarding compulsory health insurance and expressed opinions to Democratic leaders against use of booklet in Rhode Island.

Authorized showing of film "To Your Health" developed by Michigan State Medical Society in 30 theatres in Rhode Island, and appropriated $500 therefor.

Agreed to have Society pay equal amount not in excess of $50 to each district medical society for its local advertising in connection with the National Education Campaign advertising program the week of October 8.

Finances

Authorized the treasurer to establish an agency account for the Society's invested funds; to have a professional audit of the Society's books annually, and to accept from the State Department of Health the sum of $1,000 to be expended in whole or in part for the heart lectures under the auspices of the heart disease control program in Rhode Island, said lectures to be at the Medical Library.

Appropriated the sum of $250 for expenses of the Committee on Diabetes for its annual detection campaign.

Authorized the payment of the expenses of the alternate delegate of the Society to the meetings of the House of Delegates of the American Medical Association.

Library Building

Authorized the Trustees to install heating for the Medical Bureau in the basement of the Library upon advice of architect, and also to make necessary repairs or additions to provide for better disposal of rainfall and sewerage from the building.

Authorized the Trustees to close the Library building all day Saturday, effective October 1, 1950.

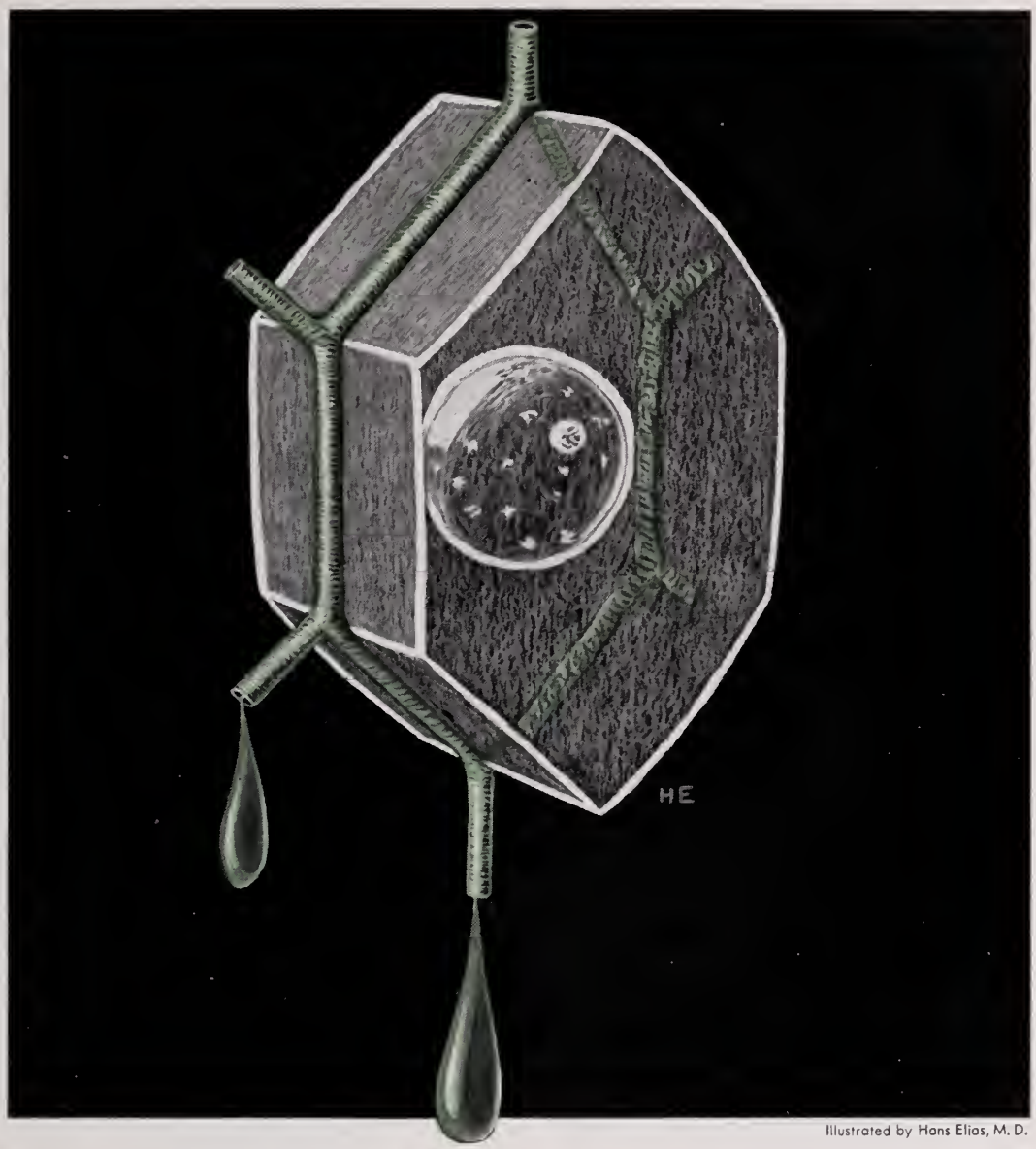
National Defense

Established a committee on national emergency medical service and authorized representation by committee at regional meeting in Boston in August. Notified Governor of Rhode Island of the desire of the Society to lend every cooperation to the State Defense organization.

Assisted the Army medical personnel in securing physicians to examine members of the armed forces called to active duty.

Established a Procurement and Assignment Committee and authorized it to act with power to meet the requirements of the First Army Command.

continued on page 606



Illustrated by Hans Elias, M. D.

THE HEPATIC CELL

To the cells constituting the secretory portion of the liver lobule is allotted the task of secreting bile to flow through the biliary tree and remove the products of congestion.

Acting on the hepatic cells, KETOCHOL®, containing the four unconjugated bile acids, stimulates the secretion of a thin, free-flowing bile which assists in promoting drainage of the hepatic tree. G. D. Searle & Co., Chicago 80, Illinois.

RESEARCH IN THE SERVICE OF MEDICINE SEARLE

HOUSE OF DELEGATES

continued from page 604

Miscellaneous

Authorized the President to establish a committee on automotive safety as advisory to the state registrar of motor vehicles, if acceptable to that office.

Received report of the Medical Grievance Committee on the matter of telephone directory listings.

Approved of the appointment of a Committee on Nutrition of the Society.

* * *

Members of the House briefly discussed the publication issued by the Democratic National Committee favoring compulsory health insurance.

* * *

There was discussion of the proposal of the Council for a Committee on Highway Safety. The discussion was concluded with a motion —

that the House of Delegates authorize the President of the Rhode Island Medical Society to establish a Committee to study the medical aspects of highway safety.

The motion was seconded and adopted.

REPORT ON RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Dr. Joseph C. O'Connell, president of Physicians Service, presented his report which is made a part of the official minutes of this meeting. The report was briefly discussed by Dr. Orland Smith, by permission of the House of Delegates. It was moved that the report be accepted and placed on file, and that the recommendations submitted in the report be approved. The motion was seconded and adopted.

* * *

The House moved —

that the President should be authorized to appoint a committee of the Society to review the master schedule of idemnities of the Physicians Service program, and it was further moved that the Board of Directors of Physicians Service be asked to consider the status of the accrued surgical-medical expense as it relates to the total reserve fund.

The motion was seconded and adopted.

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DOCTOR-DRAFT LAW

Dr. Ashworth introduced to the House Major Miller, legal officer for the Selective Service who discussed the recently enacted doctor-draft law. Major Miller summarized the main points of the legislation and indicated that Selective Service expects a directive in the near future authorizing it to cooperate with the state medical societies in determining selectees under the act.

PROCUREMENT AND ASSIGNMENT COMMITTEE

Dr. Herman A. Lawson read the report of the Committee on Procurement and Assignment, copy of which is made a part of the official records of this meeting. There was discussion by the President of the Society and others regarding the reason for the establishment of the committee at the request of the commanding general of the First Army.

It was moved to accept the report and place it on file. The motion was seconded and adopted.

RECOMMENDATIONS FROM THE COUNCIL

The Secretary reported on the following recommendations from the Council to the House of Delegates:

1. That the budget presented by the Treasurer for the year 1951, which has been reviewed by the Council, be accepted, and that the dues for 1951 be established at $40 for Fellows in practice more than one year, and $25 for newly elected Fellows and Fellows in their first year of practice.

Action: **The motion was made that the recommendation be approved. The motion was seconded and adopted.**

2. That Fellows called into active service with the armed forces be exempted from the payment of annual dues for the duration of their term of military service, effective January 1, 1951.

Action: **The motion was made that the recommendation be approved. The motion was seconded and adopted.**

3. That Charles L. Farrell, M.D., be elected as Delegate and Dr. Charles J. Ashworth elected as alternate delegate, to the House of Delegates of the American Medical Association from Rhode Island for the years 1951 and 1952.

Action: **The motion was made that the recommendation be approved. The motion was seconded and adopted.**

4. That a resolution requesting the House of Delegates of the American Medical Association to amend its By-Laws to provide for two delegates from each state association with 1,000 or less as members be considered.

continued on page 608



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Each tablet contains:
Methylcellulose .....0.5 Gm.
Cholic Acid-Maltbie..0.04 Gm.

DOSAGE: The average dose is 2-3 tablets upon retiring accompanied by a full glass of water; in severe cases 2 or 3 tablets twice daily until normal stool is obtained.

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Each Theragran Capsule contains:

Vitamin A	25,000 U.S.P. Units
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Thiamine Hydrochloride	10 mg.
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*Thiamine content raised to 10 mg.

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SQUIBB

HOUSE OF DELEGATES

continued from page 606

Action: A suggested resolution that had been mimeographed and distributed to the House of Delegates was discussed and also amended in one section. It was moved that the resolution as amended be approved. The motion was seconded and adopted and the following amended resolution was recorded:

Resolution Relative to Delegates to the American Medical Association

WHEREAS the scope of the work of the individual members to the House of Delegates of the American Medical Association has increased greatly in recent years, thereby making satisfactory representation of a constituent association by a single delegate almost impossible, and

WHEREAS there are twenty state and territorial associations faced with this serious problem of having but a single representative to inform them of the many actions of the House and its reference committees, and

WHEREAS it is vital today that each state association be adequately represented in the formation of national policies of the American Medical Association, and in turn be completely informed of the transaction of all business of the Association, therefore,

BE IT RESOLVED that the Rhode Island Medical Society, by action of its House of Delegates in meeting on September 27, 1950, request the House of Delegates of the American Medical Association to amend Chapter IX Sec. 1 (b) (c) of its By-Laws to read as follows: (Changes in italics)

"Section 1.

(B) TERM.—Delegates and alternates from constituent associations, sections, The United States Army, the United States Navy, the United States Air Force, the United States Public Health Service and the Veterans Administration shall be elected or appointed, as the case may be, for two year terms, and shall assume office on January 1 of the year succeeding their election or appointment except that incumbent delegates on the date of the adoption of these By-Laws shall serve until their successors are elected and assume office. Constituent associations entitled to more than *two* representatives shall elect them so that one-half the number, as near as may be, are elected each year.

Secretaries of constituent associations, secretaries of sections of the Scientific Assembly, the Surgeons General of the United States Army, the United States Navy and the United States Public Health Service and the Chief Medical Director of the Veterans Administration shall certify delegates and alternates to the Secretary of the American Medical Association.

(and amend)

"Section 1

(C) APPORTIONMENT.—The apportionment of delegates from each constituent state association shall be one delegate for each thousand (1,000) active members or fraction thereof *where the membership exceeds one thousand, and shall be two delegates for each state with one thousand (1,000) or less active members,* as recorded in the office of the Secretary of the American Medical Association on December 1 of each year. Such apportionment shall take effect the ensuing January 1st and shall remain effective for one year thereafter. In December of each year the Secretary of the American Medical Association shall notify each constituent association of the number of delegates to which it is entitled during the next succeeding year.

Adopted by the House of Delegates of the RHODE ISLAND MEDICAL SOCIETY, Sept. 27, 1950

BENEVOLENCE COMMITTEE

Dr. David Freedman reported on the survey of the members conducted by the Benevolence Committee. The committee asked the House to approve the following:

1. To allow the committee on Benevolence to continue its work in order to make a Benevolence Fund possible.
2. To use the legal advisors of the Society whenever it may be necessary in the formation and execution of the plan.

It was moved that the report of the Benevolence Committee be accepted and that approval be given to the recommendations set forth in the report. The motion was seconded and adopted.

DIABETES COMMITTEE

Dr. Morgan Cutts, Secretary, read the report of the Committee on Diabetes.

The report of the Committee was accepted and placed on file.

INDUSTRIAL HEALTH

Dr. Stanley Sprague presented the report of the Committee on Industrial Health. He also discussed the new state legislation providing for the administration of first aid and/or other medical services in places of employment.

The report was accepted.

COMMITTEE ON SCIENTIFIC WORK

Dr. Charles J. Ashworth gave a brief oral report of the work of the Committee in planning the midwinter meeting of the Society to be held in Woonsocket on December 13th.

continued on next page

Therapeutic dosages give therapeutic results

"...recovery from a nutritional deficiency is usually retarded if one depends only upon the vitamins supplied in food." (Spies and Butt in Duncan: Diseases of Metabolism, ed. 2, Phila., Saunders, 1947, p.495)



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RESOLUTION RELATIVE TO RESERVE MEDICAL OFFICERS

Dr. Rocco Abbate presented by request a resolution from a member of the Society requesting the defense department to delay the recall to active duty of the Active Reserve medical personnel and to grant them the same priorities extended the Reserve medical personnel who have as yet not actively served and the Civilian medical personnel to be called into Service by the Draft Act of 1950.

The resolution was discussed by members of the House.

By permission of the House Dr. Vieira, sponsor of the resolution, was permitted to present his views on the matter. There appeared to be ambiguity relative to the terminology relating to reserve officers.

It was moved that the resolution be adopted with the provision that the ambiguities noted be clarified by the president and the secretary, with the assistance of Dr. Orland Smith, a member of the Society.

The motion was seconded and adopted.

The resolution as amended stipulates as follows:

WHEREAS, the Defense Department of the United States of America is in need of medical officers in view of the Korean crisis and the impending expansion program for the Armed Forces; and

WHEREAS, the Congress has enacted laws to obtain medical personnel from the Reserve and Civilian components in a just and orderly fashion;

THEREFORE, BE IT RESOLVED, that the Defense Department be requested to delay where possible the recall to active duty of those Reserve medical officers who have already had long service, their places to be filled rather with those in the first three categories of the recent doctor draft law.

BE IT FURTHER RESOLVED, that copies of this resolution be forwarded to the American Medical Association and to the Honorable Senators and Representatives of the State of Rhode Island in Congress and that they be requested to use their good offices to have the Defense Department make such a ruling in accordance with this resolution or promote and enact legislation to this end.

PUBLIC RELATIONS

Dr. Charles L. Farrell gave a brief oral presentation of the activities of his committee, particularly in connection with the advertising program to be carried on under the National Education Campaign of the American Medical Association.

MISCELLANEOUS

Dr. Ashworth stated that he would appoint a committee to review the schedule of indemnities of Physicians Service in the immediate future.

* * *

The meeting adjourned at 10:30 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*

BENEVOLENCE COMMITTEE

Report to the House of Delegates on September 27, 1950

A questionnaire card was sent to each member of the society in order to ascertain (1) whether there was an interest in forming a Benevolence Fund and (2), if $25.00 would be too much, too little, or a good average for a yearly donation from each doctor.

Up to this time, out of about 700 cards sent, we have received replies from 174—about 25 per cent of the total membership.

Of the 174 members who replied to the questionnaire the following facts were determined:

1. 147 members (roughly 85%) were interested.
2. 26 members (roughly 15%) were not interested.

Of the 147 members interested, these facts were noted:

1. 22 members (15%) thought $25.00 yearly would be too much.
2. 19 members (13%) thought $25.00 yearly was not enough.
3. 50 members (34%) thought $25.00 yearly was adequate.
4. 56 members (38%) did not specify whether $25.00 was too much or too little but we assume they would be willing to donate $25.00.

Your committee feels that, up to this date, enough interest has been shown to warrant the establish-

continued on page 612

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1. Editorial: J.A.M.A. 141: 392 (1949).
2. Hueper, W. C.: M. Clin. North America 33: 773 (1949).

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HOUSE OF DELEGATES

continued from page 610

ment of a Benevolence Fund in this state. We believe that when the Fund becomes a reality, much more interest will be shown. Other state medical societies have had funds for the assistance or relief of needy members, their widows, widowers or minor children for many years. At the present time our immediate plans would be to assist those doctors who, through no fault of their own, become totally incapacitated for a *long* period of time and avoid their becoming "parasites" on their families or becoming "charity cases." We, as doctors, who do so much for others have this moral obligation, we believe, to one another. As our Fund grows it would be possible to extend the scope of our Benevolence to include (1) aid to widows, widowers, and minor children of doctors, (2) an educational fund from which children of deceased or disabled doctors can borrow money without interest—to be repaid to the fund some years later, and (3) retirement fund for doctors.

The bulk of the money for this fund must, of necessity, come from donations from the doctors themselves. However, other societies, have had the fund supplemented by

1. contributions from the Woman's Auxiliary
2. donations, contributions, wills, etc.
3. interest on invested money.

There is still much work to be done before our plan could operate. Your committee would like to have your approval to:

1. continue this work in order to make a Benevolence Fund possible
2. use the legal advisors of the Society whenever it may be necessary in the formation and execution of the plan.

DAVID FREEDMAN, M.D., *Chairman*
DANIEL V. TROPPOLI, M.D., MICHAEL J. O'CONNOR, M.D., HENRY J. HANLEY, M.D., GEORGE W. WATERMAN, M.D., SAMUEL FARAGO, M.D., FRANCIS KING, M.D., EDWARD TRAINOR, M.D., JOHN M. MALONE, M.D., JEANNETTE VIDAL, M.D.

INDUSTRIAL HEALTH

Report to the House of Delegates on September 27, 1950

Seventy-seven Physicians responded to our inquiry regarding industrial work, showing interest in industrial medicine and health as applied to industries in this State. At a suitable and definite time notices will be sent to these men asking them to meet for a Seminar as regards the qualifications and other requirements of these particular jobs that may be available within the year. Industrial Medicine is not just the treatment of injuries sustained while at work, in fact that is but a small part of it,

continued on page 614

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HOUSE OF DELEGATES

continued from page 612

so the varying duties of an Industrial Physician will be pointed out.

Your Chairman has been asked to address the New London (Conn.) County Medical Society in relation to the Industrial and Compensation Laws of this State on October 5th, 1950. This request will be honored to the best of our ability.

The Chairman has in view an arrangement with the R. I. Textile Association and Associated Industries to hold a meeting at which the problems of the textile mills and the medical profession may be somewhat ironed out and greater cooperation between the two improved.

This Year's A.M.A. Industrial Health Conference will be held in Atlanta, Georgia in February 1951. It is hoped that representation from this State will be possible.

The new law on the Statute Books regarding the Administration of First Aid and/or other medical services is herewith presented. With your permission an informal résumé of this law will be presented.

There is at present being given a course in Industrial Nursing arranged by the Rhode Island Industrial Nurses Association with the faculty of Boston College. I understand this is to be about 15 weeks duration (2 hours a week) and for those who complete the course some credit will be given scholastically.

There is another course in Industrial Nursing being suggested—and this one requests the approval of the Rhode Island Medical Society, and the cooperation of Brown University that will definitely give credits to graduates which will assist them in obtaining a degree in Industrial Nursing. This course is being fostered and paid for in its entirety by the Liberty Mutual Insurance Company. This will be a very exacting, instructive and full course.

Respectfully submitted,

STANLEY SPRAGUE, M.D., *Chairman*

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PHYSICIANS SERVICE

Report to the House of Delegates, September 27, 1950

Physicians Service had enrolled 84,135 subscribers by September 1, 1950. Its reserve fund on that date totalled $69,006.13.

The committee on claims has given generously of their time to study and review all questionable claims, or claims to be adjudicated on the basis of services performed that are not listed in the master schedule of indemnities. Likewise the Joint Operations Committee has been most cooperative in carrying out our program.

The Board of Directors met during July, and at that time carefully reviewed many important matters, including the question of direct enrollment. A year ago when our program was in the preliminary stages and negotiations were being concluded with the Blue Cross, at the suggestion of the President of Blue Cross, and with the approval of the officers of our corporation and the Society's legal advisor, I gave written assurance that when we had a reserve fund of $50,000 we would consider the question of direct enrollment. Naturally, I had no more indication at that time than anyone else as to what the status of the plan would be when such a reserve was attained, nor whether such a reserve would justify the risk of unrestricted direct enrollment. The Board of Directors has expressed its doubt that we are ready for this phase of the Plan at this time, but the matter will be explored further at the next meeting of the Board.

There has been expressed concern by physicians about the schedule of indemnities which was drafted some five or six years ago when we first started work on a prepaid insurance program. There is little doubt that some indemnities warrant revision upward to give the participating physicians proper and fair payment for their services. I believe, as does the executive committee of the Board of Directors, that the Rhode Island Medical Society should give this matter consideration at this time as we approach the end of our fiscal year, so that our program may be adjusted where necessary for the second benefit year.

It would also appear that if any review of the schedule of indemnities is to be made the question of indemnity for radiological services should be considered.

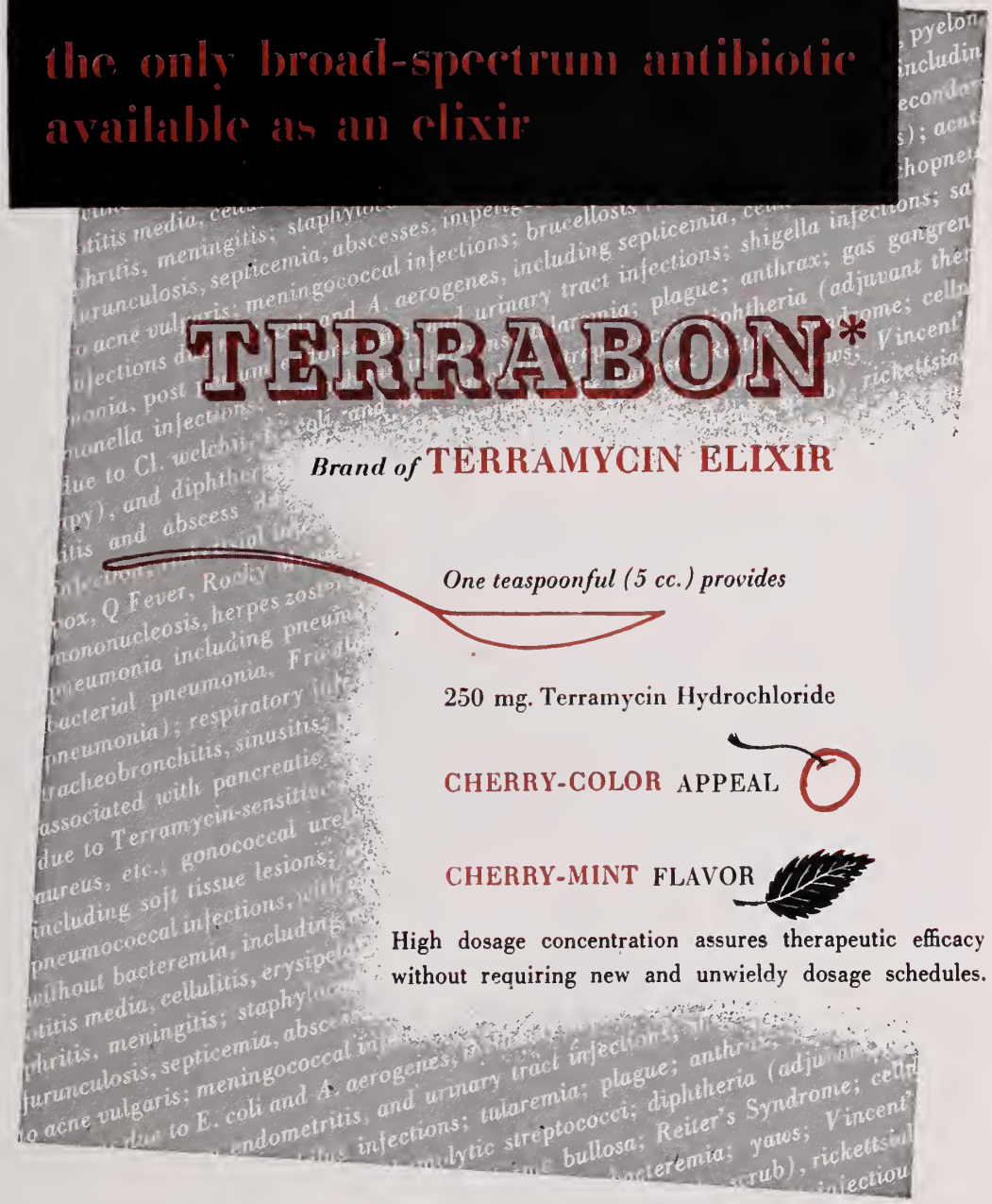
JOSEPH C. O'CONNELL, M.D., *President*
Rhode Island Medical Society Physicans Service

continued on page 616

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HOUSE OF DELEGATES
continued from page 614

PROCUREMENT AND ASSIGNMENT COMMITTEE

Report to the House of Delegates on September 27, 1950

At a special meeting of the Council of the Rhode Island Medical Society, called by the President on August 18, the undersigned committee was appointed by the President and the Council to assist the Commanding General of the First Army in the selection of medical personnel to be called to active duty. This request was made by the Commanding General at a special meeting attended by the presidents of the state societies of the New England States, New York and New Jersey. This action was taken before any legislation was adopted relative to drafting physicians for service with the armed forces.

The Commanding General of the First Army area had been ordered by the War Department to call to active service a number of medical officers in the organized reserve of the Army. A letter from the Surgeon General emphasized his great reluctance to call to duty again men who had already had active service in the Armed Forces during the War, some for periods as long as 5½ years. Although there were several thousand physicians who had received their medical education at government expense but had had no active service, the Army at that time had no legal hold upon them and could not order them into active duty.

The requirements of the emergency produced by the War in Korea made it necessary that medical officers be procured for service with the troops, before the anticipated passage of legislation by Congress which would make it possible to draft doctors into the Armed Forces. It was estimated at that time that a total of 734 reserve medical officers would have to be called to active duty. In an attempt to minimize the hardships, which would result to those individuals recalled to service, the Commanding General of the First Army had requested the advice and assistance of State Medical Societies in advising him which officers should be recalled to duty. This was the thankless task placed upon this Committee. This responsibility has been discharged. The Committee now has no duties, and whether or not it will be asked to give further assistance in the future is entirely unknown. Since the passage of the legislation with which you are all familiar, a spokesman for the Army has announced that the estimated requirements of 734 officers has been revised downward to about half that number.

The original quota from Rhode Island was 6. It was intimated by a staff officer at headquarters of the First Army that probably only 3 or 4 would be called to active duty. The Committee has no further information on this point. In view of the expressed reluctance of the Surgeon General to recall to active duty men who have had active service, the Committee in its communication to the Commanding General requested that the Surgeon General and other proper authorities give serious consideration to a plan to release these men from active duty as soon as the Army's need for medical officers had been met through the drafting of physicians made available by recent legislation. No reply to this suggestion has been received and the Committee is unable to state whether or not Army authorities will agree to such a plan.

HERMAN A. LAWSON, M.D.
JOHN A. DILLON, M.D.
MORGAN CUTTS, M.D.



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FIRST AID IN PLACES OF EMPLOYMENT

At the January Session of the 1950 General Assembly an act was passed providing for the administration of first aid and or medical services in places of employment in Rhode Island. The act will become effective on July 1, 1951. In order that every physician in the State, and particularly those engaged in any industrial medicine, may be informed of the new law, the act is published below, together with the minimum requirements of an Accident Room and of a First Aid Kit as set forth by the division of industrial inspection of the state department of labor.

. . . . . THE EDITORS.

State of Rhode Island and Providence Plantations

JANUARY SESSION, 1950

CHAPTER 2612.

AN ACT PROVIDING FOR THE ADMINISTRATION OF FIRST AID AND/OR OTHER MEDICAL SERVICES IN PLACES OF EMPLOYMENT.

H 790 A
Approved
May 1, 1950

It is enacted by the General Assembly as follows:

SECTION 1. Definitions: "Registered nurse" means a graduate nurse duly registered by the department of health and who under the supervision of a licensed physician performs any nursing service which requires application of the biological, physical or social sciences and professional nursing skills; or who engages in counselling for disease prevention and health conservation. "Registered nurse".

"Practical nurse" means a person licensed as such by the department of health and who under the supervision of a licensed physician performs prescribed physical and nursing care requiring only a knowledge of simple nursing procedures but not the knowledge and skill necessary for a registered nurse. "Practical nurse".

"First aid worker" means a person trained and qualified in a standard first aid course given by certified instructors of the American Red Cross, the United States bureau of mines or other agencies approved by the director of health. "First aid worker".

"First aid" means the immediate, necessary, temporary care given in case of accident or sudden illness before adequate medical care can be secured. It does not include continued treatment or follow-up treatment of any injury or illness. "First aid".

"Standing orders" means a written or printed compend of directions, outlining routine medical or nursing services and procedures, approved and signed by a licensed physician and acknowledged by him to be services and procedures which may, in his absence, be performed by a particular registered nurse or a particular practical nurse. "Standing orders".

SEC. 2. It shall be the duty of every person, firm or corporation operating a factory, shop, mechanical or mercantile establishment where 25 or more persons are employed, to provide for the administration of first aid, or other medical services within the limitation of this act, to any employee injured or becoming ill on their premises. First aid provisions; where 25 or more employed.

Such provision shall include procuring a first aid chest approved by the director of labor, which shall be at all times fully equipped and easily accessible.

SEC. 3. Every person, firm or corporation employing 25 to 399 persons in any factory, shop, mechanical or mercantile establishment shall designate and employ one or more persons qualified as first aid workers, or as practical nurses or as registered nurses to carry out the procedures implied in this act. Same; 25-399.

concluded on page 620

During pregnancy and lactation it is traditionally good practice to supplement the mother's diet with *iron*, *calcium*, *phosphorus*, and *vitamin D*. CADROSON tablets, a new Sharp & Dohme preparation, provide all these in proper strength and ratio, and another important mineral as well . . . *fluorine* . . . which appears to be efficient in the prophylaxis of dental caries. Moreover, fluorine-calcium supplementation has been reported valuable in aborting dental neuralgia and leg pains and cramps during pregnancy.

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FIRST AID IN PLACES OF EMPLOYMENT

concluded from page 618

Same; 400 or more.

SEC. 4. Every person, firm or corporation employing 400 or more persons in any factory, shop, mechanical or mercantile establishment shall further set aside and equip, on the premises of such factory, shop or establishment or adjacent thereto, a special accident room or similar accommodation which shall meet the approval of the director of labor.

Such accident room, its facilities and services shall be under the direction of a registered nurse.

Duties of first aid worker.

SEC. 5. The first aid worker, who may be regularly employed at other duties in the factory, shop, mechanical or mercantile establishment, shall, when rendering first aid, administer such first aid as defined in section 1 of this act.

Obligation of employer in addition to those required by workmen's compensation act.

SEC. 6. Nothing in this act shall abrogate article II, section 5, of the workmen's compensation act (chapter 300, general laws, as amended.)

Enforcement.

SEC. 7. The provisions of this act shall be enforced and administered by the division of industrial inspection in the department of labor. The director of health shall advise and assist the director of labor in the approval of first aid chests and accident rooms as provided for in this act.

Penalty.

SEC. 8. Any person, firm or corporation operating a factory, shop, mechanical or mercantile establishment, who violates any of the provisions of this act shall be deemed guilty of a misdemeanor and, on conviction thereof, shall be punished by a fine of not more than $500.00.

Act effective, when.

SEC. 9. This act shall take effect July 1, 1951 and thereupon all acts and parts of acts inconsistent herewith shall stand repealed.

Minimum Requirements of an Accident Room designated under Chapter 2612, Public Laws, 1950

It shall be located with regard to the various departments of the factory, shop, mechanical or mercantile establishment, its elevators, stairways and exits so as to be easily accessible to all employees and ambulance service if needed. It shall be so constructed as to insure the greatest quiet and privacy, with adequate natural or artificial light, adequate heating and ventilation.

The walls, floor and ceiling of such accident room shall be so constructed and finished as to be reasonably impervious and easily cleanable.

Such a room shall be furnished with a sink of reasonable dimensions, the same having a sufficient supply of hot and cold running water supplied from a potable source. The said sink shall be connected in a proper manner to a satisfactory waste line.

Toilet facilities maintained in a good sanitary manner shall be readily accessible in the area of the accident room.

The size and equipment of such a room shall be dependent on the type of factory, shop, mechanical or mercantile establishment, the number of persons employed and the types of accidents most probable to occur therein, but in no instance shall it provide less than 320 square feet floor space, and, basically, the equipment shall not be less than that required for the first aid kit.

Minimum Requirements of a First Aid Kit designated under Chapter 2612, Public Laws, 1950

It shall be soundly constructed of wood, or metal or a composition of a similar sturdy nature. It shall be so constructed that its contents shall be reasonably protected from those dusts, fumes, vapors, etc. common to the workroom or place wherein it is stored. Its closure may be secured by a simple latching device but it shall not be fitted with a locking mechanism which requires any type of key to open or close.

Said first aid kit shall contain an adequate supply of the following:

1. Sterile gauze pads—3″ x 3″ or 4″ x 4″ in individual protective wrappers.
2. Sterile gauze roller bandages 1″, 2″ and 3″ or 4″ in individual protective wrappers.
3. Sterilized absorbent cotton wool—in protective wrapper.
4. One pair bandage scissors.
5. Fresh zinc oxide, adhesive plaster or similar tape for securing dressings.
6. Sterile patch adhesive dressings for small wounds (assorted sizes) in individual protective wrappers.
7. Sterile Physiological Saline Solution in sealed container for eye wash.
8. Medicine droppers (sterile and in protective wrapper).
9. Eye cup (boilable).
10. Assorted triangular bandages.
11. Assorted splints.
12. Aromatic spirits of ammonia (individual capsules).
13. Inelastic tourniquet.
14. Paper drinking cups in protective wrappers.

The size and contents of the kit, however, shall be determined by the type of factory, shop, mechanical or mercantile establishment wherein it is to be used, the number of persons employed and the type of accidental injuries or illnesses which are most probable to occur therein.



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[1] "Fundamentals of Physical Medicine of Interest to General Practitioners," Hovarth, J.A.M.A. 136:9 (Feb. 28) 1948.

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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held on September 26, 1950. This meeting was called to order at 9:00 p. m. The minutes of the previous meeting were read and approved.

The society voted to pay for one page in the Newport *Daily News* in association with the AMA's program of public information during the month of October, 1950. A letter from Dr. Charles Farrell was read stating that the State Society would contribute $50.00 for this purpose, the balance of approximately $67.00 being voted to defray the difference by this society.

It was unanimously voted to form a committee on professional relations and hospitals in accord with the request of the State Society. It was voted that this should be a five man committee.

The following resolution presented by Dr. Frank Logler was approved:

Resolved that the Newport County Medical Society recognizes an apparent change of policy and of format in our city's newspaper, The Newport *Daily News,* and believes that in many respects the paper is greatly improved.

Whereas this is the first meeting of the society since this change and whereas the Society has most unsuccessfully tried to express its view on a certain matter to the old editorial staff, it now makes an attempt to further bring the style of reporting medical items regarding patient-doctor relationship up to date by approaching the new editorial staff as follows:

That items in local briefs refrain from mention of the particular doctor that attends a patient unless it be a major news item. This is in conformity with the method in use in city newspapers.

The Newport County Medical Society would appreciate a discussion of the matter further should need be with the president and secretary and hopes the new spirit of The *Daily News* may see fit to grant our request.

Amendment—Copy to *Daily News*—approved.

The paper of the evening was presented by Russell Maynard, Lt. Commander MC., USN, entitled "Effects of Atomic Radiations." Slides of animal tissues exposed to radiation were demonstrated.

Meeting closed 10:30 p. m.
Collation was served.

Respectfully submitted,
M. Osmond Grimes, M.D., *Secretary*

* * *

A special meeting of the Newport County Medical Society was called on July 18, 1950 to consider the application of Dr. Anthony Caputi. He was unanimously admitted to membership in this society. (Motion of Dr. Malone seconded by Dr. Logler).

Respectfully submitted,
Osmond Grimes, M.D., *Secretary*

* * *

A meeting of the Newport County Medical Society was held on May 23, 1950. The minutes of the previous meeting were read and approved. On the motion of Dr. Samuel Adelson, the revision of the construction and by-laws of the Newport Medical Society was approved unanimously by the society. The application of Dr. Anthony Caputi for membership in this society was deferred pending his residence and practice in this city.

Dr. Frank Logler reported that the House of Delegates of the Rhode Island Medical Society suggested that we in Newport organize a medical coverage plan to care for any emergency at any time in Newport County. It was the feeling of the Newport County Medical Society in this regard that Newport County was well covered but many of the populace did not seem to be aware of this fact. As a result of a motion by Dr. Samuel Adelson, the following directive was passed:

(1) That the President and Secretary of this society be empowered to assign Wednesday, holidays and weekend periods of time to the various members of the staff during which they would accept emergency calls, or otherwise, from the office of the Newport Hospital. It was felt by the society there was no need to assign men to the other nights inasmuch as there is no difficulty in getting a doctor on those nights, real or supposed.

(2) That the President and Secretary speak with the Hospital Director regarding the hospital's willingness and ability to handle calls made in this regard.

concluded on page 624

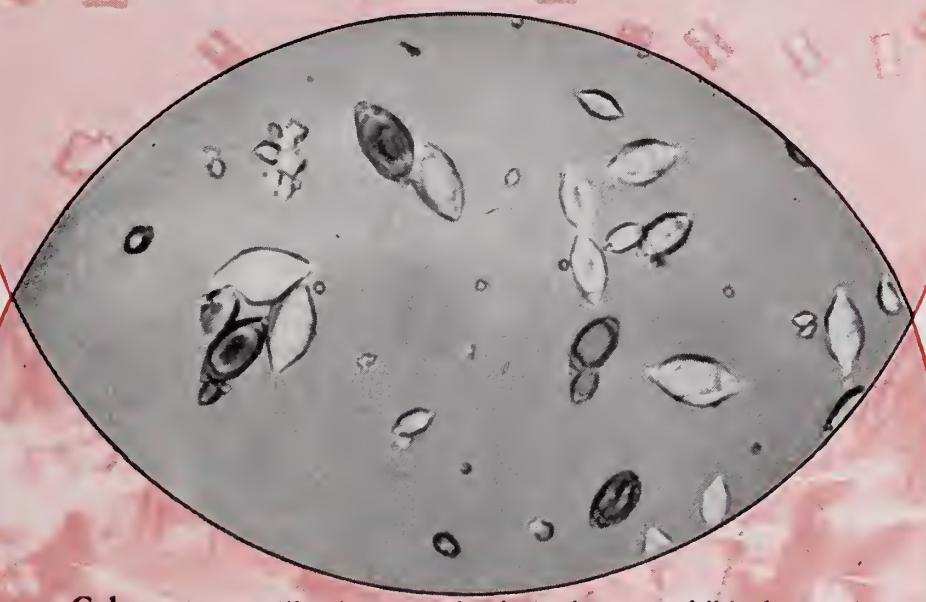
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a



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b

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NEWPORT MEDICAL SOCIETY

concluded from page 622

(3) That the local press be notified of same.

Dr. Orland Smith of Pawtucket was the speaker of the evening. He spoke of the origin and the growth of the Caducius Club and discussed many phases of medical economics. His paper was exceptionally well prepared and gratefully received.

Meeting adjourned 11:15 p. m.

Collation followed.

Respectfully submitted,

OSMOND GRIMES, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held at the Nurses Auditorium of Memorial Hospital September 21, 1950.

The meeting was called to order by President James P. Healy at 12 noon. The minutes of the June meeting were read by the secretary and accepted.

Dr. Mara, chairman of the committee on revision of the fee schedule and listing of the members according to the type of practice, reported on the study by the committee on fee schedules in other states and Rhode Island. He submitted and recommended the adoption of a schedule essentially like that of one recently disseminated by the Rhode Island Medical Society. This might be amended according to the desire of our members. This schedule includes minimum fees to be charged by general practitioners as follows:

Office visit	$3.00	House call	
First visit		Day	$5.00
additional	$1.00	Night	$7.00

Night — 7 p. m. to 8 a. m.

He recommended, also, that a card be sent to each member on which he would declare the type of practice in which he is engaged. These are to be returned within a month in order for the member to be listed in his category. Dr. Charles L. Farrell made the motion that the above recommendations be adopted. This motion was passed.

Dr. Mara had suggested that a possible $1.00 charge be considered for telephone advice. Later he made the motion that this charge be included in the fee schedule. Although, some members pointed out the justice of payment for time and advice over the phone, the majority felt that the public would misunderstand such a charge and adverse public reaction would result. This motion was dropped.

Dr. Albert Gaudet made the motion which was passed that the fee schedule be effective October 1, 1950, and that a press release be prepared by our

publicity committee to be published at the appropriate time beforehand.

Dr. Hennessey made the motion which was carried that cards or certificates be made, one of which would be placed in each member's office stating that that member is a member of the Pawtucket Medical Association and subscribes to its Principles.

Dr. Gordon made the motion that the chair appoint a committee to draw up a resolution on the passing of Dr. James L. Wheaton. This was approved and the meeting adjourned at 1:20 p. m. Attendance 27.

Respectfully submitted,

HRAD ZOLMIAN, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 2, 1950. The meeting was called to order at 8:30 p. m. by the president, Dr. Frank W. Dimmitt.

By the consent of the membership, the reading of the minutes of the preceding meeting was omitted.

The secretary reported the receipt of the communication from the Rhode Island State Sanatorium inviting members of the Association to attend the exercises dedicating the Zambarano Memorial at the sanatorium on Thursday, October 12.

The president reported that the committee of Dr. William H. Foley and Dr. Herbert H. Armington had filed with the secretary the Association's tribute to the late Jacob S. Kelley, M.D.

The president called upon Dr. John C. Ham to read the tribute to the late Dr. Ubaldo E. Zambarano which was prepared by Drs. Anthony Corvese, Frank A. Merlino, and John C. Ham.

The secretary reported that the Executive Committee recommended to the committee for active membership to the Association the following physicians:

Charles W. Cashman, M.D.
Joseph J. Lambiase, M.D.
Donald S. McCann, M.D.
George F. Mahoney, M.D.
Margaret Messinger, M.D.
Sumner Raphael, M.D.
Abraham Saltzman, M.D.

It was moved that these applicants for membership be elected, and the motion was seconded and adopted.

Dr. Dimmitt introduced as the first speaker Dr. David S. Howell, formerly of Rhode Island Hospital and presently on the staff of Philadelphia General Hospital, who spoke on "The Circulatory Manifestations of Obstruction of the Superior Vena Cava in a Patient with Portal Hypertension."

continued on next page

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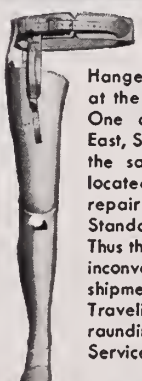
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Dr. Howell presented a case with the Superior Mediastinal Syndrome. Symptoms were morning cough followed later dysphagia and choking, and still one month later with hoarseness. Fluroscopy revealed a mass in the Superior Mediastinum. A characteristic physical finding was distension of the superficial veins of the head and chest. The venous pressure in the upper extremities is always high in these cases. In this case, the left arm had a venous pressure of 347, whereas, the femoral vein had a pressure of 130. Also compression of the esophagus and trachea occurs as well as esophageal varices high in the esophagus.

33% are due to malignant tumors, 26% to aortic aneurysm. Other causes are purulent mediastinitis lymphoma, and chronic fibrinous mediastinitis due to trauma.

Frequent pressure reading of the veins will give the progress of the disease. The prognosis in cases of aneurysm and malignancy is poor.

Dr. Dimmitt announced that the Association was meeting jointly with the heart disease control program of the Rhode Island State Department of Health which is being conducted in cooperation with the Committee on Postgraduate Education of the Rhode Island Medical Society. He then turned the chair over to Dr. Marshall Fulton, chairman of the State Society's committee, who introduced Dr. Robert E. Gross of Boston, William E. Ladd, Professor of Surgery, Harvard Medical School, and Surgeon-in-Chief, Children's Medical Center.

Dr. Gross presented a magnificent discussion of surgery in heart disease.

In patent ductus arteriosus, there is a characteristic machinery like murmur. Following incision and ligation of the ductus, the diastolic blood pressure rises from 40 to 80, the systolic shows no change. The heart shrinks to normal and the left ventricular output drops to less than one-half.

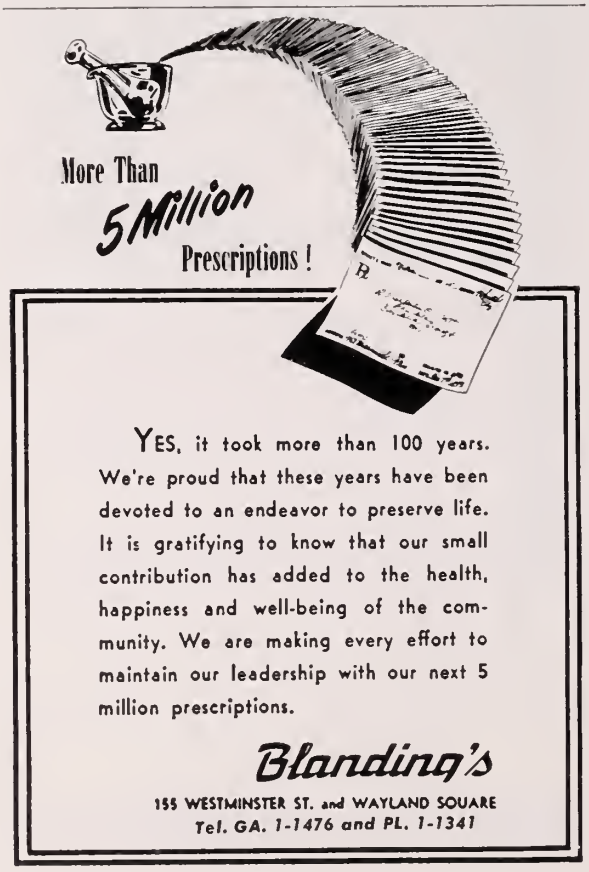
The two main changes that occur in the Tetralogy of Tallot is an overriding of the aorta over a septal defect, and obstruction at the pulmonary valve with a decreased flow into the pulmonary system. The patients have cyanosis and polycythemia and tire easily. They squat because of this. This is quite characteristic. E. K. G. shows a right axis deviation. The x-ray is also suggestive. The heart is not especially enlarged except at the right ventricle which pushes the apex upwards and gives a boot appearance. This reduced flow into the pulmonary bed can be corrected by surgery. This is done by anastomosing one of the larger vessels, usually the subclavian artery, to the pulmonary artery. The oxygen saturation rises from 33 to 70-80%. These patients can exercise more after surgery.

There is a pure and simple pulmonary stenosis without a septal defect. The orifice is diminished in size. The orifice is enlarged surgically. The pulmonary artery beyond is dilated even though the pressure is lower than normal. A valvotome is pushed thru the stenosed area and pulled back with blades open. This enlarges the opening.

In coarctation of the aorta, we may find other associated anomalies. Usually we find a systolic murmur best heard in the back. Also the enlarged intercostals which are acting a colaterals can be felt in the back as pulsations. The heart is enlarged by x-ray, but the aortic knob is small or absent. X-rays also shows notching of the esophagus by barium swallow due to the enlarged intercostals. Angiography is resorted to only in doubtful cases to make a diagnosis. E. K. G. shows marked right axis deviation.

Surgically the stenosed portion is excised and aorta sutured together end to end. In some cases where the defect is great, a graft is used to bridge the span. Blood vessel banks are kept for this purpose.

Another abnormality treated surgically is a double aortic arch with the trachea in the center. The trachea and esophagus become compressed. Occasionally we find a ductus arteriosus running from the pulmonary artery around to the right aorta constricting the trachea. These patients have stridor and are subject to colds and pneumonia. The child holds his head back because he can breathe better.



The meeting adjourned at 10:45 p. m.
Collation was served.
Attendance 135 members, 60 guests.

Respectfully submitted,
DANIEL V. TROPPOLI, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY
(September 1950)

A regular monthly meeting of the Kent County Medical Society was called to order by Vice-President Jean Maynard in the absence of President Joseph C. Kent. Meeting commenced at 9 p. m. The Secretary was then asked to read a communication from the Rhode Island Medical Society concerning a brochure entitled "Better Medical care that *you* can afford." This was printed and distributed by the Democratic National Committee. It was requested that this brochure be shown to the membership at the next regular meeting, and that if members discover that any of these brochures are being distributed in this area, kindly notify the Executive Secretary of the Rhode Island Medical Society.

Dr. Abbate then made a motion that a protest be made. A discussion followed and it was then decided that this matter be tabled until the next meeting.

The next new business to be discussed was that brought up by Dr. Benjamin Tefft concerning an Essay Contest sponsored by the Association of Physicians and Surgeons entitled "Why the private practice of medicine furnishes this Country with the best medical care." This essay contest is open to high school students in various high schools throughout the country; it being a national contest with $1700 in prizes paid by the Association of Physicians and Surgeons. Motion was then made after a discussion that the society sponsor essays in this County. This was seconded by Dr. Wittig. Dr. Collom then moved that Dr. Tefft be appointed to name a committee. This was so voted.

Following the regular business meeting two members of the Board of Trustees of the Kent County Memorial Hospital were then introduced to the members of the society. They were Mr. Albert Ruerat and Mr. Edward Devine. Mr. Ruerat was called upon to give a complete and comprehensive report of the progress of the new hospital. This report traced the early planning of the need for the new hospital thru the hectic campaigns for funds necessary to complete the building. Mr. Ruerat brought out all the trials and tribulations encountered in the early phases of construction. He discussed the results of the fund raising campaigns and the ultimate needs before the hospital is opened for patients. After the completion of Mr. Ruerat's report there followed an

continued on next page

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open discussion by the members, of many matters brought up in the board of directors' review of the hospital construction and the campaign for funds.

Meeting adjourned at 10:30 p. m.

Respectfully submitted,
E. T. HACKMAN, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

A regular monthly meeting of the Kent County Medical Society was held on May 23, 1950 at 1515 West Shore Road.

Meeting was called to order at 9:30 p. m. by President Joseph C. Kent. The minutes of the previous meeting were read and approved. A discussion then followed concerning a date for the annual clambake. Doctor Taggart and Doctor Hudson once again were unanimously endorsed as the planning committee. Location of the bake—Flat River Club, Time, Thursday, June 22. Doctor Davies again extended invitations to his annual cocktail party preceding the bake.

Dr. J. Vidal then was asked to discuss the proceedings of the Benevolence Committee. This primarily was to establish a fund for such physicians and their families. The right to solicit funds and to discuss the aim to members of each society was the plan of this Committee. Dr. Arthur E. Hardy moved that the Kent County Medical Society endorse such a fund. This was seconded by Dr. Phillips and the motion was so voted.

Following the regular business meeting the speaker of the evening was then introduced. Dr. Arthur E. Hardy lectured on the topic, "Surgery of the Hand."

Meeting adjourned at 10:30 p. m.

Respectfully submitted,
E. T. HACKMAN, M.D., *Secretary*

COMMITTEES ON PROFESSIONAL RELATIONS AND HOSPITALS

Rhode Island Medical Society Committee:
Arthur Hardy, M.D., *Chairman*
Howard Turner, M.D.
John H. Gordon, M.D.
Osmond Grimes, M.D.
Alfred E. King, M.D.

Providence Medical Association:
Howard Turner, M.D., *Chairman*
Vincent Ryan, M.D.
Joseph G. McWilliams, M.D.
Russell Bray, M.D.
Herman A. Winkler, M.D.

Pawtucket Medical Association:
John H. Gordon, M.D., *Chairman*
Armand A. Bertini, M.D.
Edward T. Trainor, M.D.
William N. Kalcounos, M.D.
Earl J. Mara, M.D.

Newport County Medical Society:
Osmond Grimes, M.D., *Chairman*
James C. Callahan, M.D.
Donald Fletcher, M.D.
Samuel Adelson, M.D.
Alfred Tartaglino, M.D.

Kent County Medical Society:
Arthur Hardy, M.D., *Chairman*
George Young, M.D.
Joseph Wittig, M.D.
Harold Collom, M.D.
Fenwick Taggart, M.D.

Woonsocket District Medical Society:
Alfred E. King, M.D., *Chairman*
Alton Thomas, M.D.
Leo Dugas, M.D.
Thomas J. Lalor, M.D.
Saul Wittes, M.D.

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METASTATIC KRUKENBERG TUMOR OF THE OVARY

concluded from page 593

sented a typical case in which the primary lesion was believed to be in the breast.

The author wishes to express his gratitude to Walter T. Dannreuther, M. D., of New York City, for permission to publish this case, and also for his assistance in the preparation of this paper.

Bibliography

1 Meigs, J. V.: Tumors of the Female Pelvic Organs, Macmillan, Boston, 1934.
2 Taylor, H. C.: Am. Jour. of Cancer 15:277:1931.
3 Geschickter, C. F.: Diseases of the Breast, Lippincott, Philadelphia, 1943.
4 Cheatle & Cutler: Tumors of the Breast, Lippincott, Philadelphia.
5 Novak, E.: Gynecological and Obstetrical Pathology, Saunders, Philadelphia, 1947.
6 Willis, R. A.: The Spread of Tumors in the Human Body, Churchill, 1931, London, W. I.
7 Meyer, R.: Henke, F., and Lubarsch, O., Handbuchder Spegiellen Pathologischen Anatomie and Histologie, Volume 7-1; 533, 1930.
8 Hundley, J. J., Jr.: Krukenberg Tumors of the Ovary and other Secondary Ovarian Carcinomas, Southern Med. Jour. 23:579:1931.
9 Jarcho, J.: Krukenberg Tumors, Further Studies, Amer. Jour. Surgery, 41:538:1938.
10 Norris, C. C. & Vogt, M. E.: Malignant Ovarian Neoplasms: Amer. Jour. of Obs. and Gyn., 10:684:1925.
11 Novak, E. & Gray, L. A.: Krukenberg Tumors of the Ovary; Clinical and Pathological study of 21 cases. Surgery, Gyn., and Obs., 66:157:1938.
12 Robinson, M. R.: Primary and Secondary Cancer of the Ovary, Amer. Jour. of Obs. and Gyn., 51:321:1930
13 Slaughter, D. P.: Multiplicity of Origin of Malignant Tumors, Int. Abs. Surg., 79:89:1944.
14 Affutt: Relationship of Carcinoma of Body of the Uterus and the Ovaries. Surg., Gyn., and Obs., 54:490:1932.
15 Lahm, W.: Das Carcinom des Uterus, Halban, J. and Seitz, L. Biologie and Pathologie des Weibes. Band IV, Urban and Schwarzenberg, 1928.
16 Zeigerman, J. H.: Krukenberg Tumor with Osteoplastic Metastases, Amer. Jour. Obs. and Gyn., 56:187:1948.
17 Foote, N. C.: Pathology in Surgery, Lippincott, 1945.

BOOK REVIEWS

HANDBOOK OF OBSTETRICS AND DIAGNOSTIC GYNECOLOGY, by Leo Doyle, M.S., M.D. University Medical Publishers, Palo Alto, California. First Edition, 1950. $2.00. 240 pages; 42 illustrations.

This manual should be a worthwhile contribution to the Library of either the trained Obstetrician, the General Practitioner, or the House Officer.

It is concisely organized in outline form making for ease of reference, and, included in the early and later pages are valuable tables suggesting possible laboratory tests and presenting their physiological normals in the pregnant and non-pregnant state.

This volume is disproportionally divided with 85 per cent of its text dealing with Obstetrics, and but 15 percent with Diagnostic Gynecology; but this, I believe, was the intention of the author. He recognizes clearly the constant changes in treatment of the various pelvic diseases and plans yearly revision to keep it up-to-date.

He presents clearly a very adequate and orderly method for the investigation of the problems of infertility and suggests further references which are classic as far as complete understanding is concerned.

Endometriosis is discussed briefly, but the newer concepts of hormonal therapy are all adequately discussed.

There is no mention of lesions of the vulva, and very little space is given to the discussion of carcinoma of the reproductive tract.

On the other hand, the portion of the handbook devoted to Obstetrics is very complete and current. He discusses induction of Labor with intravenous pitocin, abdominal puncture for the treatment of acute polyhydramnios, the value of anti-Rh titres in cases of suspected erythroblastosis, and the lower segment Cesarean section.

The book is sparsely, but well illustrated; and, I believe it will find its greatest value as a house officer's manual.

H. C. McDuff, Jr., M.D.

TEXTBOOK OF ENDOCRINOLOGY, Edited by Robert H. Williams, M.D., W. B. Saunders Company, 1950.

It is a truism that textbooks of medicine in these times of rapid advances may be out-of-date before they are published. This lag, possibly an unavoidable one in view of the mechanics of assembling and publishing several contributions, is reflected in the present edition, even though it is dated 1950. For example, in the section on the pituitary it is stated that "Thus far adrenotropic hormone has not been used much therapeutically." The discussion of the therapeutic application of cortisone is limited to Addison's Disease. The reader will look in vain for what has become the most promising application of endocrinology — the ability of these pituitary and adrenal hormones to cause remissions and even cures in a surprising variety of diseases, many hitherto considered chronic or incurable.

The text surveys adequately the entire field of endocrinology and includes even a chapter on obesity. The latter, however, (written by L. H. Newburgh) is included primarily to show that excessive fat is nearly always exogenous and rarely belongs in the field of pathologic endocrinology. The treatment of this common disorder is well outlined although the role of appetite-depressants is not mentioned.

The text is liberally illustrated and the colored photographs especially are excellent. In a number of instances, however, reproductions of roentgenograms and tissue sections are on too small a scale to present adequately the details referred to in the text.

It would have been of great assistance to the practitioner to have included an appendix list of the various commerical endocrine preparations (such as has been included in other manuals). The variety of trade names and chemical variations, such as different esters, are capitalized upon by competing pharmaceutical houses and confuse those without special training in endocrinology. A path through this morass could have well been provided. At the other extreme, for a general text, the procedure for determining time of ovulation by basal temperature graphs is presented in lengthy detail.

continued on next page

In general, it may be said that Dr. Williams and his contributors have well covered the basic background and clinical features of endocrine diseases. The manner and length of presentation makes it valuable primarily to the medical student, the specialist in the field, and for reference. It is to be hoped that an early second edition will include the recent advances in the clinical applications of the adrenal pituitary axis which have made an understanding of them obligatory for practitioners in every field of medicine.

IRVING A. BECK, M.D.

BOOKS RECEIVED

The Librarian reports the receipt of the following books:

PHYSICIAN'S HANDBOOK by Marcus A. Krupp, Norman J. Sweet, Ernest Jawetz and Charles D. Armstrong. 6th ed. University Medical Publishers, Palo Alto, Calif., 1950.

The 6th edition of this excellent pocket-reference HANDBOOK has been thoroughly revised. Several new sections have been added including those dealing with electrocardiography, electroencephalography, radioisotopes and simplified laboratory procedures.

THE NATIONAL FORMULARY. Prepared by the Committee on National Formulary under the supervision of the Council by authority of the American Pharmaceutical Association. Wash., D. C., 1950. 9th ed.

The NATIONAL FORMULARY, designated in 1906 as one of the two official compendia by the terms of the Federal Food and Drugs Law, has undergone a thorough revision and several new features have been added. Supplements are to be issued in order that the FORMULARY may keep pace with the rapid development of new drugs.

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bar pneumonia with bacteremia

er initiation of Chloromycetin therapy the temperature returned
ıormal within forty-eight hours, and prompt subsidence of the
gh and chest pain occurred."[1]

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witt, W. L., and Williams, Jr., B.: New England J. Med. *242*:119, 1950.
cinos, Jr., A.; Ross, S.; Olshaker, B., and Twible, E.: New England
Med. *241*:733, 1949.
od, E. J.: Lancet 2:55, 1949.

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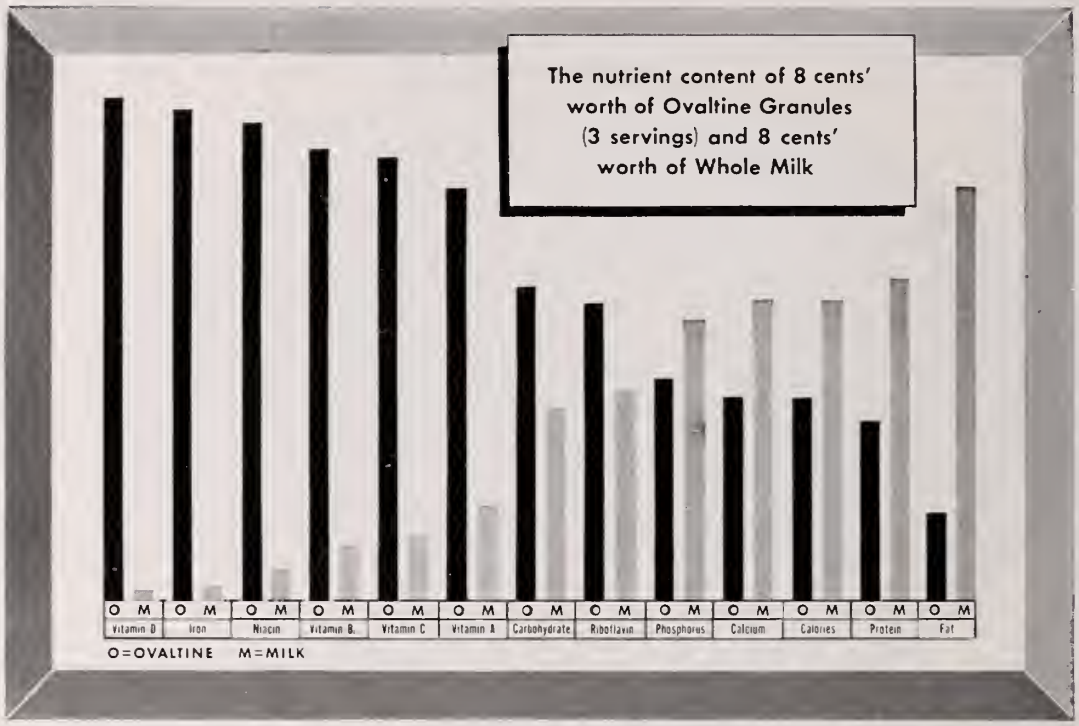
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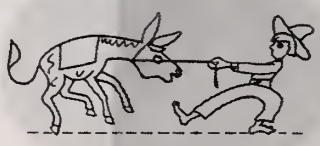
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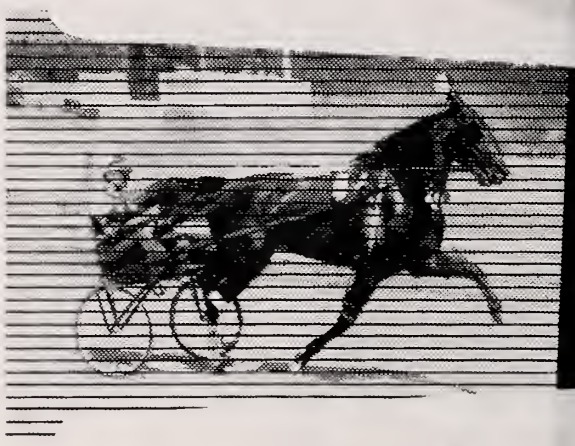
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1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

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1. J.A.M.A. 143:858, 1950.
2. Morrison, L. M. and Johnson, K. D.: Amer. Heart J. 39:31, 1950.
3. Joslin, E. P.: Rev. Gastroent. 17:545, 1950.
4. Herrmann, G. R.: Exp. Med. & Surg. 5:149, May-Aug. 1947.
5. Leinwand, I. and Moore, D. H.: Amer. Heart J. 38:3, Sept. 1949.
6. Felch, W. C.: N. Y. Med. 5:16, Oct. 20, 1949.
7. Pomeranze, J. and Levine, V.: Rev. of Gastroent. 16:771, Oct. 1949.
8. Morrison, L. and Gonzalez, W. F.: Amer. Heart J. 38:471, Sept. 1949.

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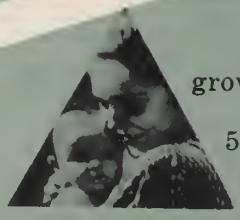
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bibliography

1. Lancet 2:10, July 1942.
2. Ebbs, J. H.: Handbook of Nutrition, Chapt. XX, Chicago; Amer. Med. Assn. 1942.
3. Burke, B. S.: Obst. & Gynec. Survey 3:716, 1948.
4. Burke, B. S. and Stuart, H. C.: J.A.M.A. 137:119, 1948.
5. Tompkins, W. T.: Bull. N. Y. Acad. Med. 24:376, 1948.
6. Tompkins, W. T.: J. Int. Coll. Surg. 4:147, 1941.
7. Burke, B. S.: Currents in Nutrition, 1950.
8. Biskind, M. S.: Vitamins and Hormones 4:147, 1946.

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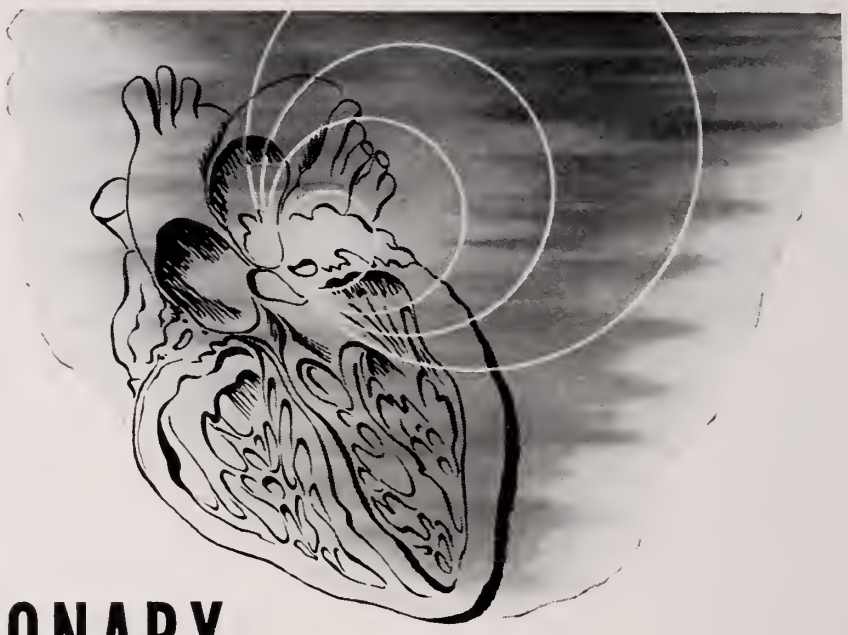
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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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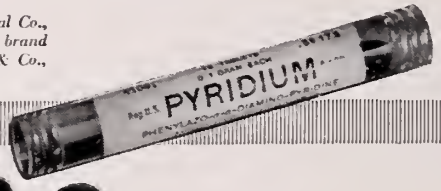
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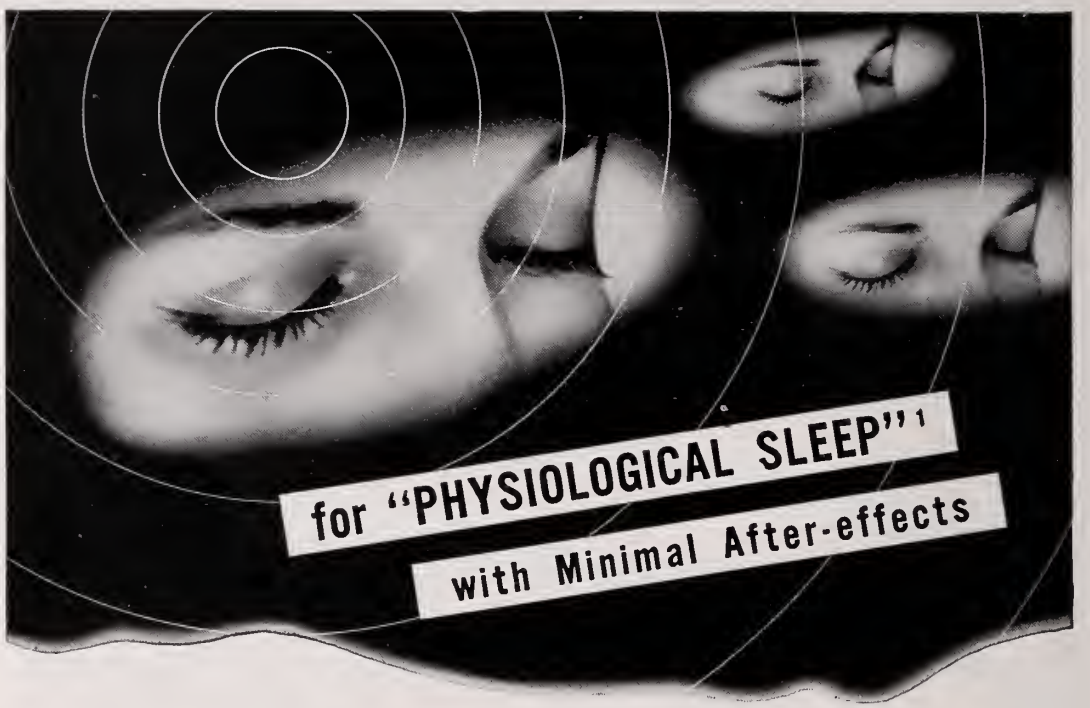
1. Blake, F. G.; Friau, G. J., and Wagner, R. R.: Yale J. Biol. and Med. 22:495 (July) 1950.

2. Herrell, W. E.; Heilman, F. R.; Wellman, W. E., and Bartholomew, L. A.: Proc. Staff Meet. Mayo Clin. 25:183 (Apr. 12) 1950.

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[1]N.N.R., 1947, p. 398.
[2]Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

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TREATMENT OF HYPERTENSIVE VASCULAR DISEASE BY SODIUM RESTRICTION*

MICHAEL DIMAIO, M.D.

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SODIUM RESTRICTION is not the answer to the treatment of hypertension. Proof of this simple statement is the fact that there is little agreement among investigators as to the exact value of sodium restriction in this very important medical problem. The reasons for the widely divergent reports are not entirely clear but several important considerations occur to me in evaluating the discrepancies in the various reports. Therefore, before presenting the results of sodium restriction in hypertension, I should like to review these considerations so that my position on this problem may be clear from the outset.

The first consideration that arises is that which pertains to the etiology of the hypertension: Is the hypertension essential or is it the so-called malignant, rapidly progressive form of hypertension which occurs in the younger age group and which carries with it a grave prognosis? Is the hypertension secondary to some other condition such as primary renal disease? Is the hypertension due to some unusual or remedial condition such as that which is associated with pheochromocytoma; or is the hypertension part of the picture of coarctation of the aorta? The importance of investigating the etiology of every case of hypertension was clearly demonstrated to me not very long ago at a large medical center. The case was that of a young woman who had had a bilateral lumbo-dorsal sympathectomy for a severe degree of hypertension. Her hypertension persisted following operation but what was most puzzling was the fact that the usual symptomatic relief was lacking. Re-evaluation of the patient's problem at a later date disclosed that her hypertension was secondary to a cardiovascular anomaly, namely, a coarctation of the aorta. Every one knows that nothing short of a repair of the defective aorta would have had any beneficial effect on her hypertension. Yes, not even a low sodium diet!

Other considerations which occur to me pertain particularly to the type of diet used and the total daily intake of sodium. The utter lack of palatability of all low sodium diets also brings up the question of the degree of cooperation that exists among doctor, patient, and patient's family. And what proof beyond the patient's word does the physician have that the patient is following his diet instructions accurately? Experience has proved beyond a doubt that the patient's word must be taken with a grain of salt (provided the physician is not on a low sodium diet) when asked if he has been faithful to the diet. The temptation for the patient to add extra grains of salt to his diet is indeed great when he is confronted with the dreadful, unpalatable low sodium diet.

The results of this study apply primarily to essential and malignant hypertension and the various grades of hypertension which occur between these two extremes. All the patients received the same diet, the only difference being the total daily caloric intake which was adjusted according to the patient's weight. Only those patients who showed a good to excellent degree of cooperation were included in this report.

In this brief presentation, no attempt will be made to discuss the numerous theoretical considerations of sodium chloride and water metabolism or the rationale of sodium restriction in hypertension. Nor will I compare the relative merits of the sodium restriction diet employed in this study with the Rice Diet.

Seventy-three patients were studied; fifty-two were females and twenty-one were males. Four patients were studied and treated in the hospital while the remainder, sixty-nine, were ambulatory. The patients were under constant medical supervision for periods of several weeks to 26 months.

continued on next page

* Presented at the 139th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 11, 1950.

When originally seen, each patient was carefully examined and the basal blood pressure levels determined as closely as possible. In each instance, a careful search was made to determine the etiology of the hypertension.

Following a careful physical examination, the routine laboratory procedures were as follows: a routine urinalysis including urine chlorides; a complete blood count; blood urea nitrogen and creatinine when indicated; an X-ray of the chest, and an electrocardiogram. After the completion of these preliminary details, each patient was instructed on the use and application of the low sodium diet. On subsequent visits, blood pressure determinations were always made in the same manner, by the same observer, with a mercury manometer.

Four or five readings were recorded at one minute intervals with the subject in the sitting position. This was then repeated with the subject in the reclining position. The average of the several blood pressure readings was considered the true reading for any one examination.

Each patient was examined every two to three weeks for the first one or two months and then regularly at monthly intervals. In this manner, it was possible to make repeated blood pressure, urinary chlorides, and weight determinations and to review possible misunderstandings and/or errors in the application of the diet. The urinary chloride test, which is a simple and accurate office procedure, has proved of considerable value in detecting extra amounts of sodium chloride ingested by the occasional patient. My experience has been that when a patient was informed that any additional salt ingested was reflected by a proportional increase in the sodium chloride in the urine, he was more apt to cooperate.

The diet* employed was a low sodium - high potassium diet which was developed at the Rhode Island Hospital over three years ago.

Tables I through III give some idea of the essential food elements and other data which make up the low sodium - high potassium diet used in this study.

	Low Sodium—High Potassium Diet GRAMS	*Rice Diet (9) GRAMS*
Sodium	0.168 (168.6 mg)	0.2
Chloride	0.690 (690.8 mg)	0.15
Potassium	4.79 (4,790.0 mg)	2.0—3.0
Cholesterol	0.940 (940 mg)	0
Carbohydrate	335.0	460.0
Fat	32.0	5.0
Protein	65.0	20.0
Calories	1888.0	2000.0

TABLE I

*See acknowledgment on page 655.

Table I shows the average daily values of some of the essential food elements in the diet herein used as compared with the rice diet.

Table II shows the comparative amount of sodium chloride and sodium present in various hospital diets as well as in the diet under discussion and in the rice diet.

DIET	*SODIUM CHLORIDE GRAMS*	*SODIUM GRAMS*
Average diet without salt restriction	6—15	2.4—6.0
Average diet without salt at table	4—7	1.6—2.8
Average diet without salt added in cooking or at table	3—4	1.2—1.6
"Low Salt Diet"	1—2	0.4—0.8
Low Sodium—High Potassium Diet	0.4—0.5	0.168—0.2
Rice Diet	0.5	0.2

TABLE II

Table III shows the minimal daily dietary allowances recommended by the National Research Council and the daily vitamin and mineral content of the low sodium diet under discussion. The full diet has all the necessary vitamins.

	National Research Council	*Low Sodium — High Potassium Diet*
Vitamin A	5000.0 I. U.	11,748.0 I. U.
Thiamine (B_1)	1.5 mgm.	1.54 mgm.
Riboflavin (B_2)	2.0 mgm.	1.35 mgm.
Niacin (Nicotinic Acid)	18.0 mgm.	18.18 mgm.
Ascorbic Acid	75.0 mgm.	307.36 mgm.
Iron	12.0 mgm.	18.15 mgm.
Calcium	0.8 grams	0.655 gm. (655.0 mgm.)
Phosphorus	0.88 grams	1.112 gm. (1112.0 mgm.)
Iodine	0.150—0.300 mgm.	0.11 mgm.

TABLE III

The story of what happened to the blood pressure of these patients during the period of sodium restriction can be best demonstrated by a few representative case summaries.

Figure 1 shows a group of ten patients with essential hypertension (with symptoms) treated by sodium restriction for periods of from 40 to 220 days. The ages ranged from 35 to 75 years. The original blood pressure readings ranged from 174/100 mm. Hg. to 224/110 mm. Hg. The graphs show that the readings at the time of this report had improved considerably.

Figure 2, C.L., a 62-year-old female with hypertensive vascular disease and chronic nephritis of 2 to 4 years' duration. She was also a mild diabetic. When originally seen, her blood pressure was

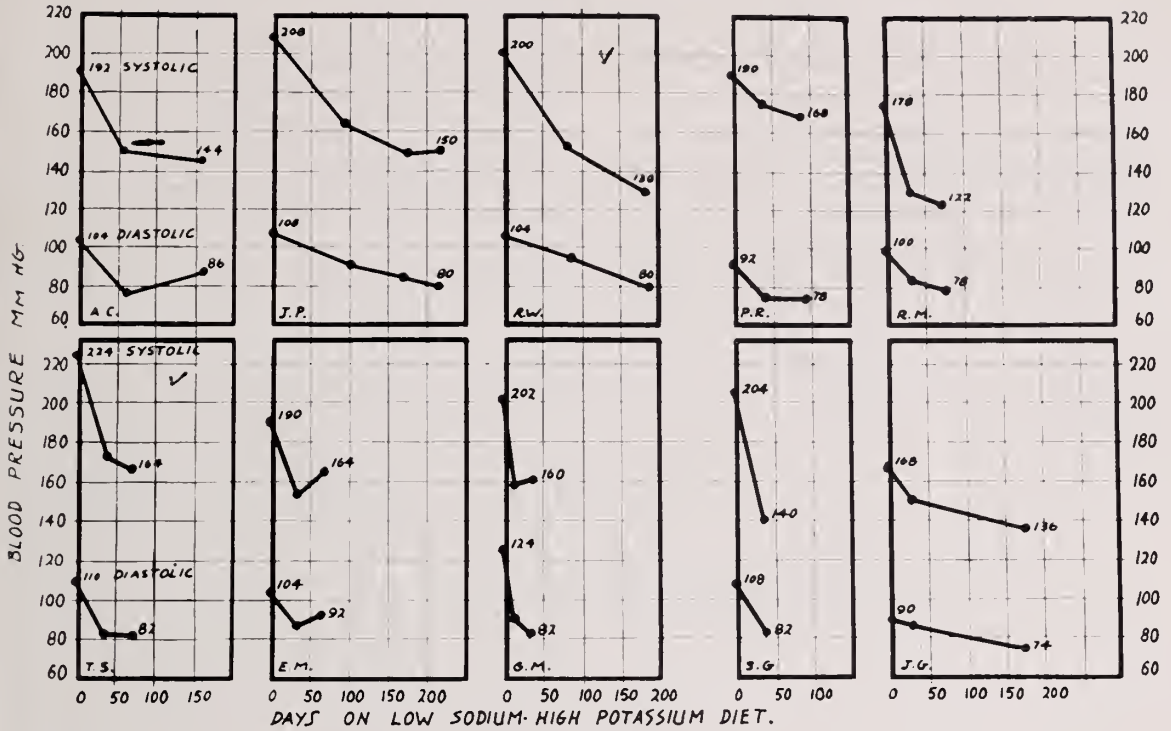


FIG. 1

210/120 mm. Hg. With perfect cooperation, within 10 days her blood pressure dropped precipitously and remained so for one month. Following this initial period of observation, the patient was not seen again until 228 days (7½ months) later, during which period she followed no dietary regimen whatsoever. The graph clearly shows what happened to her blood pressure during this period of dietary indiscretion. The low sodium - high potassium diet was again instituted and again a drop in blood pressure followed only to rise again when the patient found it too difficult to cooperate.

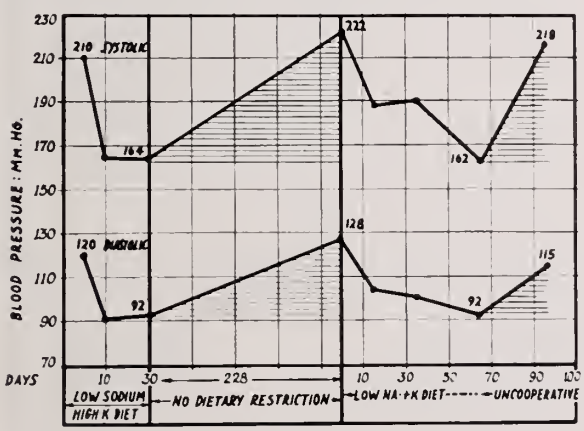


FIG. 2

Figure 3. V.S., a 51-year-old male with hypertensive vascular disease of two years' duration. Grade III changes were noted in the fundi. He also had latent syphilis. When originally seen, his blood pressure averaged 200/108 mm. Hg. On the low sodium - high potassium diet, his blood pressure dropped to satisfactory levels. The patient went off his diet completely for one month and upon his return visit, the blood pressure averaged 204/114 mm. Hg. Reinstitution of the diet again resulted in a fairly satisfactory drop in blood pressure. This case and the preceding one would seem to lend support to the idea that an intimate relationship exists between sodium metabolism and hypertension.

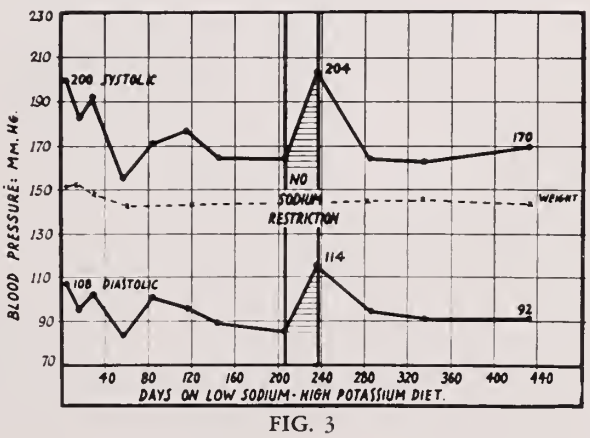


FIG. 3

Figure 4. C.M., a 56-year-old female with hypertension of 6 to 7 years' duration, grade III fundi changes, chronic nephritis, and obesity. When initially seen, her blood pressure averaged 230/124

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mm. Hg. Within three weeks, the patient's blood pressure was entirely normal and remained so until the patient liberalized her diet. When last seen on this liberal diet, her blood pressure was considerably higher, averaging 190/112 mm. Hg.

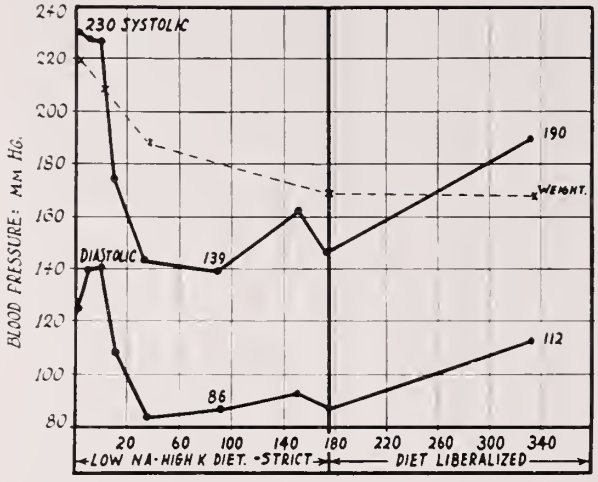


FIG. 4

Figure 5, L.C., a 35-year-old female with malignant hypertension and bilateral papilledema (grade IV retinitis). In 1941, she had a normal blood pressure. In 1944, it was approximately 170/120 mm. Hg. In 1947, she was admitted to the hospital because of high blood pressure, uncontrollable headaches, dizziness, blurred vision, and nocturnal dyspnea. Original blood pressure determinations averaged 230/146 mm. Hg. For the first 10 days in the hospital, the patient continued to have distressing headaches which were not controlled by any form of medication. However, about 3 days after the institution of the low sodium - high potassium diet, the patient became symptom-free and felt as though a drop in blood pressure had occurred when actually the blood pressure remained high, averaging 215/130 mm. Hg. This patient demonstrates the favorable effect sodium restriction may have on the distressing symptoms of hypertension in the absence of any appreciable drop in blood pressure.

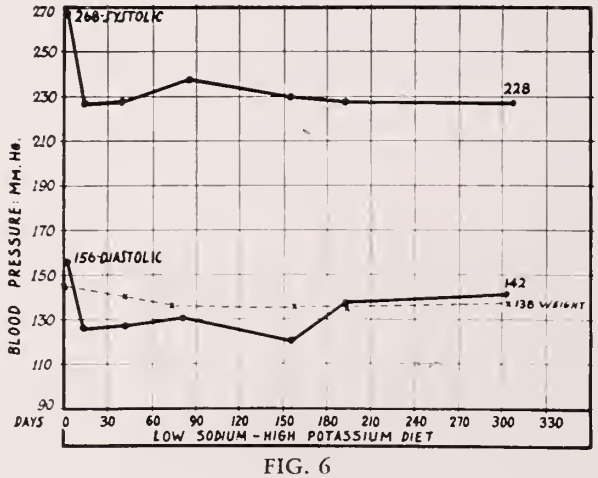


FIG. 6

Figure 6, A.T., a 59-year-old male with hypertension of two years' duration. He had grade IV retinitis with marked loss of visual acuity. His initial blood pressure determinations averaged 268/156 mm. Hg. He has been a very cooperative patient during the past 16 months but here again no drop in blood pressure has occurred. However, the patient feels that his blood pressure level is considerably lower than when first seen because he is absolutely symptom free and his vision has improved considerably. He has worked steadily since sodium restriction was started.

Figure 7, A.S., a 64-year-old male diabetic of 24 years' duration, controlled by insulin and diet. He had been in a moderate degree of failure for two years. He was hospitalized in December of 1948 because of hypertension, massive anasarca, left pleural effusion and albuminuria. His initial blood pressure averaged 208/108 mm. Hg. Within two weeks after the institution of the low sodium - high potassium diet, his blood pressure was entirely normal. His edema disappeared rapidly and he has been free of congestive failure since then. Blood pressure now, 16 months later, averages 144/70 mm. Hg.

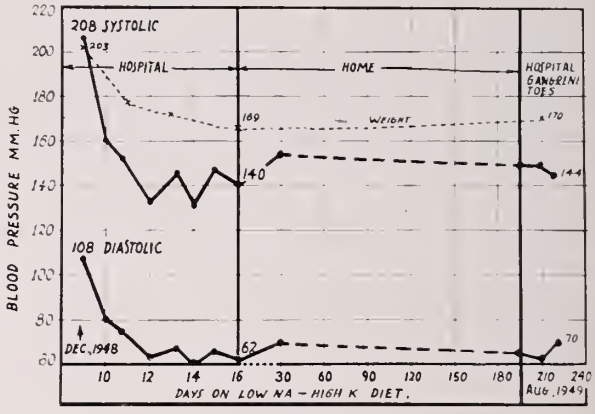


FIG. 7

Figure 8, H.C., a 50-year-old female with hypertensive vascular disease for approximately 3½ years. Her blood pressure in 1944 was 180 systolic.

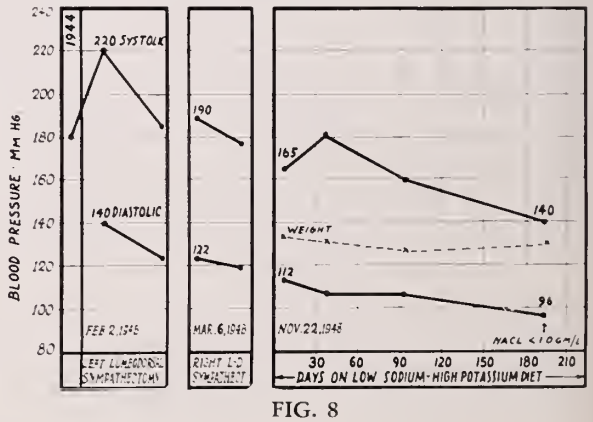


FIG. 8

Because of severe headaches, anginal pains, and grade III retinal changes, a bilateral lumbo-dorsal sympathectomy was performed in 1948. Blood pressure before operation was 220/140 mm. Hg. My original examination, six months after her operation, revealed a blood pressure which ranged from 165 to 180 systolic and 112 diastolic. She was placed on the low sodium - high potassium diet, cooperated excellently, and after a period of 190 days (6½ months) her blood pressure averaged 140/96 mm. Hg. Patient has been free of symptoms since the institution of the diet.

Figure 9, B.A., a 40-year-old male who has had hypertension since 1944 and severe headaches, dizziness, and progressive loss of vision since June 1945. Early in 1946, he had nearly lost the vision in his left eye and the visual acuity in the right eye was greatly diminished. Because of these findings, a bilateral lumbo-dorsal sympathectomy was performed in 1946. Blood pressure determinations before operation averaged 226/136 mm. Hg. A kidney biopsy revealed arteriolar sclerosis. Following surgery, there was a complete disappearance of symptoms and his vision improved remarkably. However, within a few weeks following discharge, the blood pressure ranged from 200 to 224 mm. Hg. systolic and 110 to 130 mm. Hg. diastolic where it remained until early in 1948 when headaches and blurring of vision were again beginning to manifest themselves. The surgeon referred the patient for a

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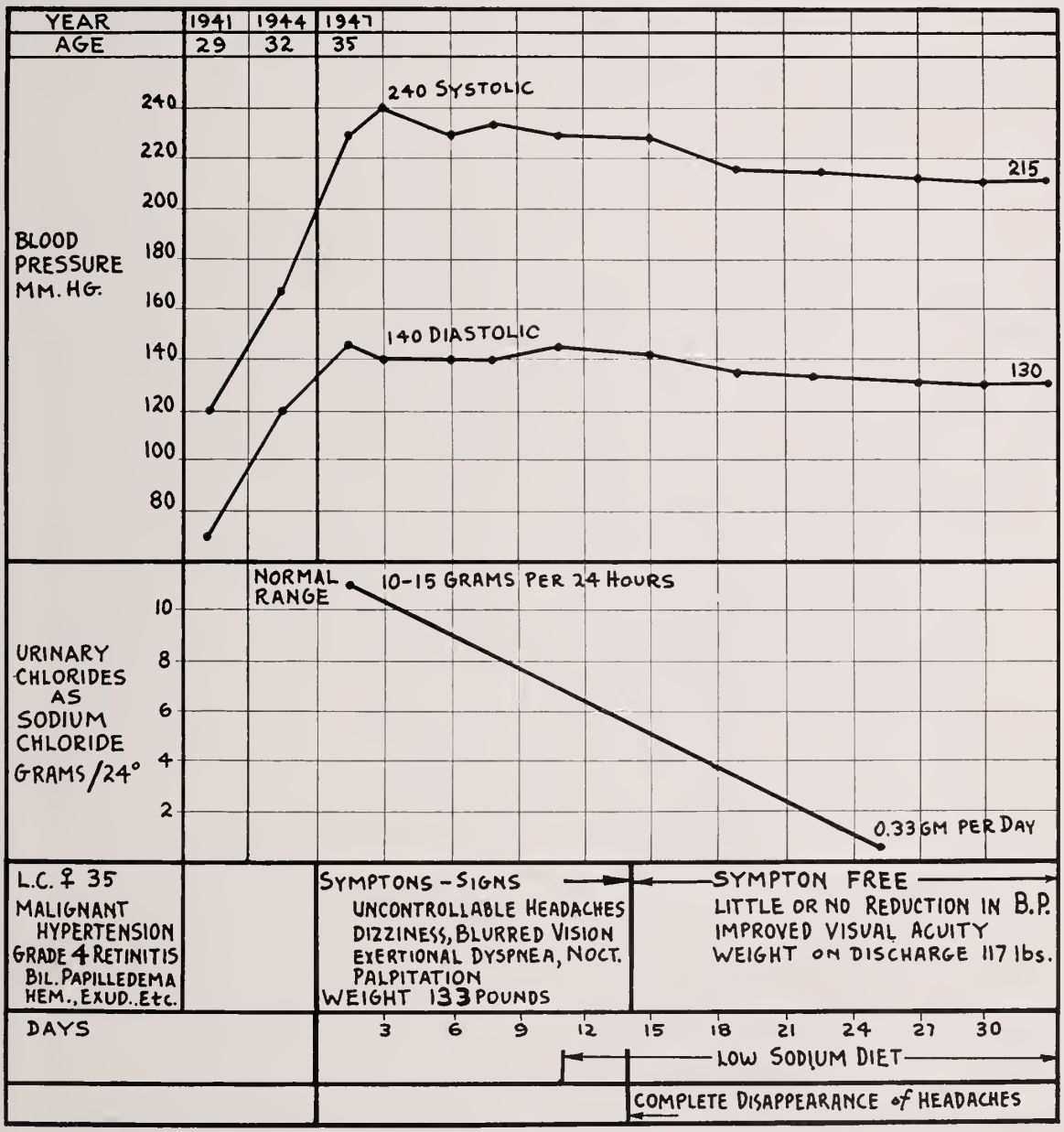


FIG. 5

trial on sodium restriction. Within two weeks after the institution of sodium restriction, the blood pressure averaged 154/88 mm. Hg. where it had remained with slight variation for one year. However, within the past year, in spite of excellent cooperation on the part of the patient, the tendency has been for the blood pressure to rise. The patient was last seen approximately six weeks ago and blood pressure at that time was 190/100 mm. Hg. Despite this, the patient has continued to work and has remained symptom free throughout the past two years.

Figure 10, A.R., a 42-year-old female with hypertension of 5 to 7 years' duration, grade II retinal changes. Blood pressure in 1947 averaged 220/120 mm. Hg. In 1949, prior to the institution of the low sodium - high potassium diet, her blood pressure averaged 220/115 mm. Hg. She has been under observation for a period of 7 months and when last seen, her blood pressure was 162/92 mm. Hg. and she was symptom free.

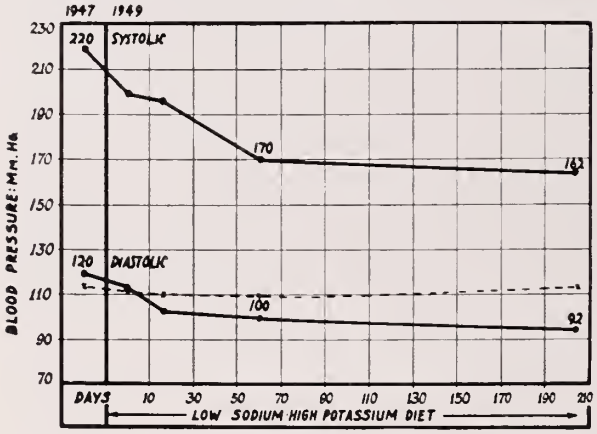


FIG. 10

Figure 11, E.C., a 47-year-old male with hypertension of 14 years' duration. He had renal stones in 1925 and again in 1936, and a streptococcic pharyngitis in 1935. He had grade III retinitis. His blood pressure had been as high as 215/126 mm. Hg. My initial blood pressure revealed an average of 190/110 mm. Hg. With excellent cooperation, his blood pressure dropped considerably. Eight months ago, his blood pressure was 138/88 mm. Hg. and now is in the vicinity of 152/80 mm. Hg. This patient has been under observation for over two years.

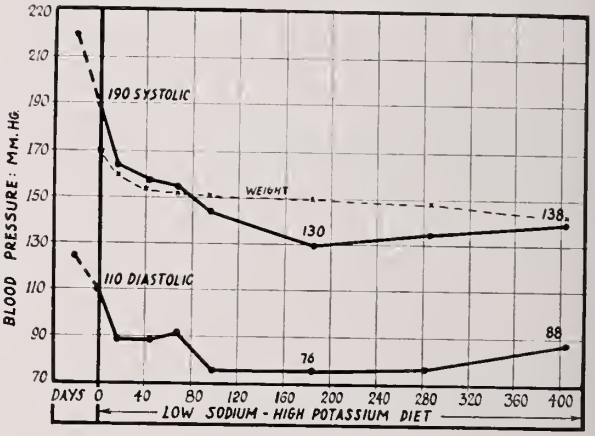


FIG. 11

Figure 12, P.R., a 38-year-old male physician who had a slight elevation in blood pressure and albuminuria in 1941 following an attack of streptococcic pharyngitis. He experienced severe headaches and dizziness in August of 1948. He took his own blood pressure and found it to be 260/140 mm. Hg. He was hospitalized in a large Boston clinic and his admission blood pressure there was 200/135 mm. Hg. He had a grade IV retinitis, albuminuria

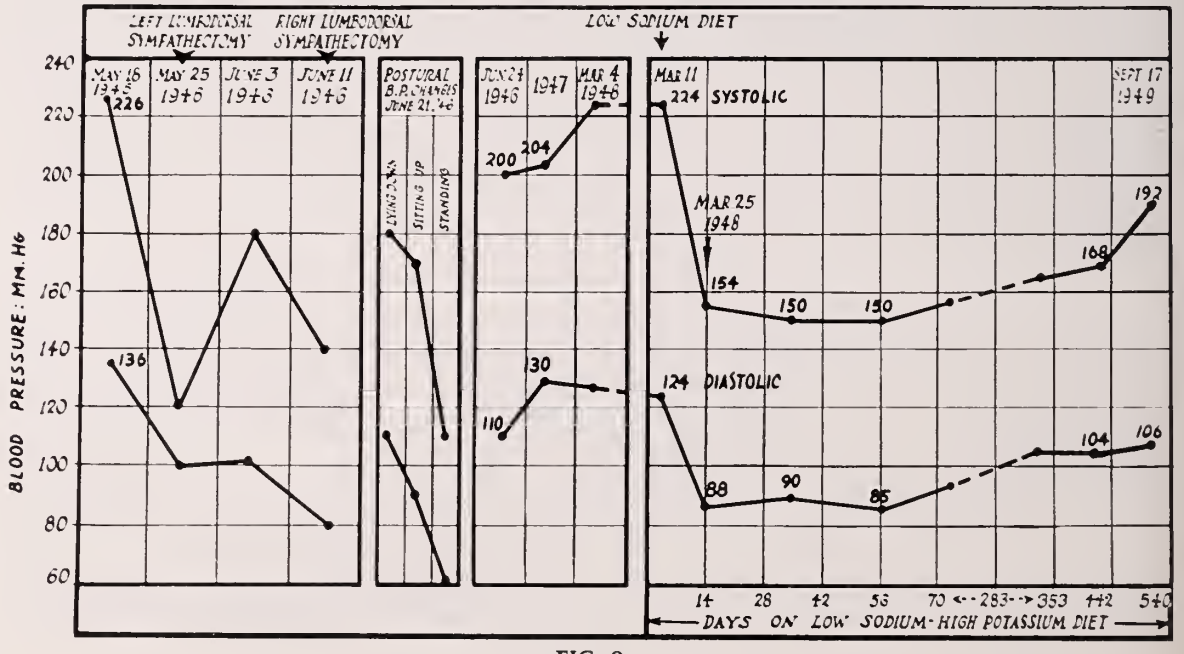


FIG. 9

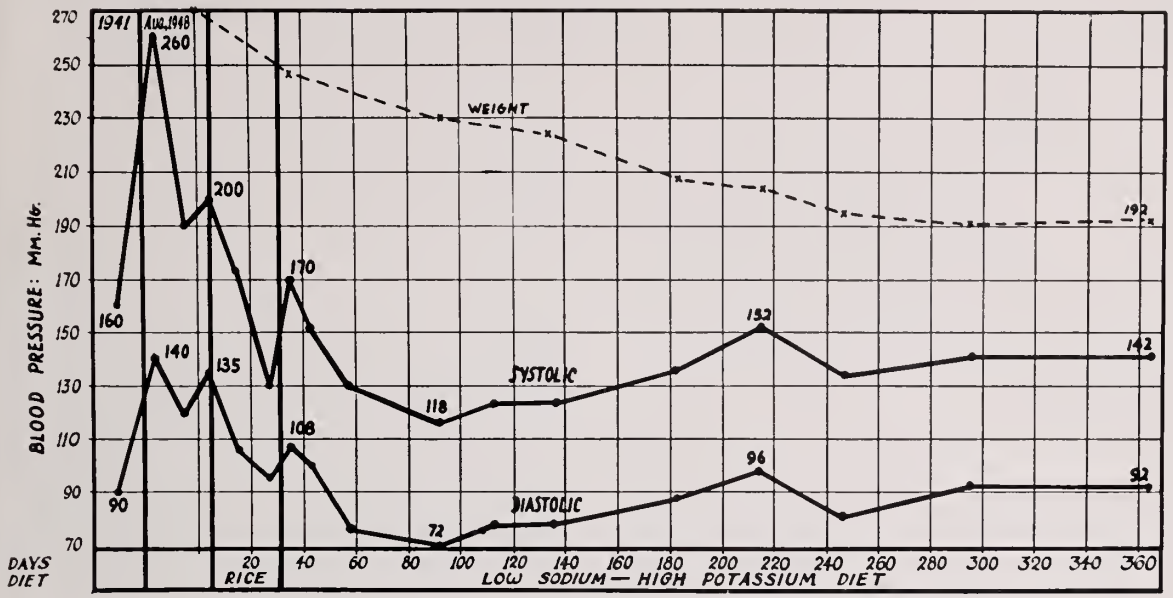


FIG. 12

and non-protein nitrogen values varied between 47 to 51 mg. per cent. He was placed on the rice diet while at the clinic and remained on it for approximately one month. As is clearly shown, he had a striking drop in blood pressure on this dietary regimen but the patient found it difficult to continue on the rice diet for very long because of nausea and vomiting. It was following this experience that the low sodium - high potassium diet was started. Figure 12 shows the dramatic drop in blood pressure this patient experienced on sodium restriction. He remains symptom free and has lost approximately 90 lbs. in the two years that he has been on the low sodium - high potassium diet.

Table IV represents the summary of the 73 patients treated by the low sodium - high potassium diet. It shows the number of cases in each of the four grades of hypertension and is self-explanatory.

No. Cases	Grade of Eyeground Changes	Significant Drop in Blood Pressure		Insignificant Drop in Blood Pressure		Clinically Improved		Not Improved		Expired		Poor Cooperation	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
21	I	21	100	—	—	21	100	—	—	—	—	1	48
22	II	15	68	7	32	22	100	—	—	—	—	0	0
21	III	14	67	6	28	18	86	3	14	1	5	7	33
9	IV	3	33	4	44	7	78	2	22	2	22	0	0
73		53	73%	17	23%	68	93%	5	7%	3	4%	8	11%

Summary of 73 hypertensive patients treated medically by a low sodium - high potassium diet for a period of 1 to 26 mos.

TABLE IV

Summary

In general, a significant drop in blood pressure occurred in 73% of the patients with hypertension whereas 93% of the patients of all grades were clinically improved. Approximately 11% of the patients in this study showed poor cooperation.

Conclusions

In conclusion, I should like to repeat that sodium restriction is not the answer to the treatment of hypertension. However, until better methods of treatment are available, one should not hesitate to give sodium restriction a trial in the management of hypertensive vascular disease.

*ACKNOWLEDGMENT. I am indebted to Miss Ruth Mather, Therapeutic Dietician, Rhode Island Hospital, and to Miss Hazel Parry, formerly of the Rhode Island Hospital, for their assistance in the preparation of the low sodium - high potassium diet used in this study.

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THE DOCTOR AND THE NATIONAL EMERGENCY*

BRIGADIER GENERAL PAUL I. ROBINSON, MC, U.S.A.

The Author, *Brigadier General Paul I. Robinson, MC, U.S.A., Chief, Personnel Division, Office of the Surgeon General.*

THE CURRENT EMERGENCY began rather abruptly with a clash between military forces of a nation that had been severed in the occupation negotiations following the end of hostilities in World War II. It was quickly decided that the United States, as a member of the United Nations, would resist the aggression of the North Koreans in South Korea. Almost immediately our Nation was faced with the task of rendering medical service to our people participating in the combat which followed.

Following World War II the Army established residency training programs in its large hospitals. These programs were established on the advice of such eminent educators as Dr. Hugh Morgan, and thousands of physicians throughout the Nation have assisted the Army in making the training of exceptionally high standard. All have been submitted to the proper authorities within the profession for adjudication and accreditization. It was not long until it was evident that young physicians who decided on careers in the Army desired, and demanded, an opportunity to pursue residency training. These young men had been indoctrinated in their medical schools with the firm belief that it was necessary for them to pursue 2, 3, or 4 years of postgraduate training before they were suited to begin their medical careers. Furthermore, the physicians in the military service had largely been assigned to management duties of one type or another during the war, and in order for them to again assume medical care functions, it was necessary that they be re-trained. The residency programs were an admirable medium for this accomplishment. Whereas the Army had only 75 board specialists in its regular service at the end of World War II, it now has, as a result of its intensive training efforts, 202. In addition, there are about 300 Regular Army medical officers who are in the practice phase of training preparatory to taking the examinations of the specialty boards. In contrast to civilian life, the Army is able to conduct a controlled residency training program and place in that program only those to meet specific requirements, by specialty, for the years ahead. On advice of civilian medical educators, this program has been devised so that in 5 or 6 years, about 30% of the Regular Army Medical Corps will be board-certified specialists. In order that those in general practice in the Army would be brought to the same high standards in medical accomplishment, residencies in general practice were also begun.

Recruitments for Korea

None of us had thought of the residency program as a pool of officers who could be called upon in an emergency. But at the beginning of the Korean conflict, there were only some 190 Army physicians in the entire Far East Command, comprising Japan, Okinawa, Guam, the Philippines, and Korea. The staffing requirement for the then existing force was 425 physicians. The Army Medical Service had been rendering medical care with far fewer physicians than it required, and the Far East Command was no different than all other areas. It was obviously necessary to increase the number of physicians in the Far East very rapidly.

Appeals were made to all the company grade officers in our Reserve. Response was very low, in fact of the more than 3,000 who received letters, only 40 volunteered for immediate active duty. We next thought of those in residency programs. Our large 5 teaching hospitals had very small permanently assigned staffs, a residency staff which was, even at that time, below the number that could have been accommodated under available clinical material criteria, and a normal number of interns. In other words, all residents could not be taken from the program if the hospitals were to continue to function. Therefore, it was decided to reduce each service to the minimum considered necessary for the continuation of medical care in the hospital. This was done, and 132 residents were sent from military hospitals to the Far East by air early in July. In addition, we had 101 officers who had just finished internships the 30th of June, who could be made available immediately to the Far East; and they too, were flown to Japan early in July.

More than 2 years ago, in an endeavor to produce more rapidly the number of trained physicians

* Presented at the New England Post Graduate Assembly, at Boston, Massachusetts, November 7, 1950.

needed in the Army, we embarked upon a program whereby we commissioned officers in civilian life who had acceptable residencies, and allowed them to continue in those residencies. It was evident that they, too, would have to be brought on duty in order to meet our responsibilities for medical care. Wires were sent to the superintendents of the hospitals in which they were located, and with very few exceptions all agreed to assist us in making their release effective as soon as possible. Eighty-nine of these civilian residents were also flown to the Far East. In order to augment the medical strength in support of the combat, stations throughout the United States were further depleted; and as of this date there are approximately 750 physicians in the Far East Command. All medical commanders are qualified by training or experience in World War II and a large majority of the Medical Service Corps officers have had courses at our Medical Field Service School.

The Army Medical Service has rendered medical care for American troops in the Korean conflict largely by utilization of the physicians on hand at the beginning of the conflict. Because of its training programs, it was able to furnish officers in all of the required specialties, and present indications are that the medical care was creditable in every respect.

Considering both the time period and troop strength involved, casualties in the Korean campaign have been quite heavy. The wounded-in-action of the first 3 months equalled the number of American wounded in the first 1½ years of our participation in World War II. Despite this, there is every indication that an extraordinary record is in the making. In World War I, for example, the fatality rate for wounded soldiers reaching treatment centers was over 6 percent in World War II, this rate had fallen to 4½ percent. Today, despite the admittedly incomplete nature of our statistics, it appears likely the fatality rate will drop to something less than one-half of the World War II rate.

Contributing materially to this fine record was the splendid work done by Air Force and Navy evacuation planes in the rapid movement of large numbers of patients, both within Korea and Japan and between the Far East and the United States.

Doctor Draft Legislation

Soon after the beginning of the Korean conflict, Congress authorized the armed forces to call upon their Reserves to effect the necessary expansion. On 10 August 1950, the Army placed its first call for medical officers with the Army Commanders. This call was for only 734 physicians. At about the same time the medical profession of the United States endorsed legislation to require service of physicians who were trained at Government expense, or those who did not serve in World War II. This legislation was in the form of an amendment to the existing Selective Service Act. It was passed by the Congress and became Public Law 779 on 9 September 1950. This law placed former ASTP and V-12 participants and those deferred to pursue medical education during World War II in first priority for service. On 16 October they were registered by the Selective Service System. The President has directed that this group of young physicians be utilized before calls are made on those who served in World War II. Before the President's directive had been promulgated, the Army had already decided that it could reduce the number of Reserve officers with World War II experience by approximately one-half. In fact, the original 734 call was reduced to 364. But since the President's letter cancelled even this call, special authority had to be obtained to order 130 company grade officers, and 149 field grade officers to duty to meet urgent demands that could not await the implementation of Public Law 779. All company grade officers were notified with their orders that they would be released from the service and allowed to return to their homes as early as possible, probably in January or February. This same provision does not apply to the field grade officers, who are the commanders and the specialists required for positions of responsibility. In addition, the Navy has loaned the Army 570 physicians until replacements can be obtained.

In endorsing legislation calling for draft of physicians, the medical profession undoubtedly, after consideration of all means whereby it could support the armed forces, decided that the least disruption to the physicians of the Nation would be caused if the Priority I and II groups would be called first. It now appears that approximately 85 percent of these young physicians are in some type of residency training in hospitals throughout America. Many hospitals, in surveying their numbers who fall within these groups, have found that one-half or more may be subject to service under the law. Many feel that their teaching programs will be severely handicapped, and some are of the opinion that their medical care programs actually may suffer. Both conditions would be true if all Priority I and II physicians were called into service immediately. While figures are not available at the present time, it would seem likely that one-half of the residents who fall into Priority I or II of the law might be called to duty within the next six or eight months. Teaching hospitals should immediately prepare themselves to meet this loss. Our experience in the Army has indicated that it can be met, although, of course, it does require additional effort on the part of many individuals. But we believe that our experience indicates that this can be done without severe disruption.

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Many young physicians themselves are asking the question if they can be allowed to finish their current year in residency programs. Obviously no such commitment could be considered by the armed forces, because it is impossible to look into the future to determine to what extent our forces will remain in combat. The President has emphasized that events in Korea will in no way deter the planned expansion of the armed forces. In the Army, this expansion is to take place during the next eight months. Obviously, then, residents cannot be deferred until next July.

Mechanism for Call to Active Duty

The mechanism of bringing registrants to active duty appears complicated. We have done everything in our power to align the various Government agencies so the process will be as simple as it can be made. The Army, only, has submitted a request to the Selective Service System. Those classified as available for immediate active duty by the Selective Service System will be ordered for their pre-induction physical examinations beginning 16 November. An information form filled out on registration by each individual indicates whether or not the registrant desires a commission. The papers of *all* registrants, regardless of their stated desire for commissions, are forwarded by the Selective Service System, after pre-induction physical examination, to the Army Commanders. The Army Commander determines the acceptability of the registrant for active duty. If he is found acceptable and has requested a commission, the Army Commander is authorized to commission the registrant in the Corps that corresponds to his profession. The registrant is then instructed to notify his local board of the fact that he holds a commission. For those who have stated they do not desire a commission, the Army Commander also makes the decision as to the acceptability and returns these forms to the Selective Serivce System, at which time induction processes begin. Each local board will have a quota and will begin processing individuals for call to duty under this quota. Those who have received commissions and are thus eligible for call to active duty are to be subtracted from the quota of the local board. The question has been asked, especially by those in residency programs, as to how long they can withhold applying for a commission and still be able to obtain one. This has been a most difficult question to answer because it is the desire of all of us in the military, and the Selective Service System as well, that no physician be inducted into the service as a recruit. Since the Army is the only Department which has placed a requisition with the Selective Service System, it is more or less incumbent on the Army to answer this very pointed question: What is the latest time a registrant may apply for a commission and receive it before being inducted? This question is under study by the Personnel Policy Board of the Office of the Secretary of Defense. The Army, in the meantime, has expressed its opinion that a physician may not expect to receive a commission if he waits until he receives his induction notice before applying. I would like to add here that the Army will make every effort to process applications as rapidly as possible, but I would not guarantee that commissions could be assured on applications received after the notice for induction is received by the individual.

If all registrants would say they desire a commission, or if all would say they do not, there would be no problem of distributing the orders to active duty. If just enough obtain commissions to fill the military requirements and the military is forced to call them to active duty, it would appear that those who indicated they did not desire a commission have won for themselves a deferment. In any event, such a deferment can only be temporary and those individuals are taking a chance that they will be suddenly called and be unable to avail themselves of a commission before being inducted.

There is nothing to prevent any physician who so desires, to apply for a commission before being sent for his pre-induction physical examination. He must consider that he is eligible for call to duty when he accepts the commission, because this complies with the spirit of the legislation and the desire of the profession. Many have been encouraged to apply for commissions before their pre-induction physical examinations. Certain advantages accrue to them individually, in that they are more likely to get assignments within their spheres of interest and training. If they do have such assignments, they have a better chance of obtaining accreditization from their specialty boards for the experience they accrue while in the service. The needs of the armed forces in the immediate months ahead are more acute than they will be later, and those who do obtain commissions early and come on active duty will undoubtedly gain a source of personal satisfaction from the service that they render.

Physical Standards

There have been differences in the physical standards for officers and enlisted men for the military service for a great many years. For the commissioning of individuals under this law, however, the physical standards which apply for induction of enlisted men have been made applicable. In other words, an individual under P. L. 779 who meets the physical requirements for induction is eligible for commission in the Medical, Dental, or Veterinary Corps. This does not mean that an individual who barely meets induction standards would be eligible for a career in the regular service.

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CIRCULATORY MANIFESTATIONS OF OBSTRUCTION OF THE SUPERIOR VENA CAVA IN A PATIENT WITH PORTAL HYPERTENSION*

DAVID S. HOWELL, M.D.

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THE FIRST authentic case of obstruction of the superior vena cava was reported by William Hunter in 1757 in *Medical Observations and Inquiries.* Since 1903 when Sir William Osler described two cases with autopsy findings and reviewed the literature,[2] Fischer,[3] Rauth,[4] Dana,[5] and Ehrlich, Ballon and Graham[6] have reviewed the literature and given comprehensive reports. An excellent description of the symptoms and signs of this syndrome based on anatomical variations was made by Hinshaw and Rutledge.[7] Recently, a compilation of the world literature up to 1946 was made by McIntire and Sykes,[1] who list a bibliography including 524 cases. However, in none of the cases was the superior mediastinal syndrome associated with portal hypertension or esophageal varices. For this reason, the following case report is made and the superior mediastinal syndrome is reviewed.

Case Report

W. B. No. 457618 — R. I. H.

This 59-year-old male was admitted November 26, 1949. The patient had been well until November, 1948, when he first noticed a morning cough, producing a small amount of whitish sputum which persisted throughout the year before admission. In August, 1949, there appeared dysphagia and a choking sensation associated with his cough. One month later he began to have hoarseness and felt that food was delayed in the mid-esophagus. In November, three weeks prior to entry, he suffered increasing weakness, fatigue, dyspnea on exertion and orthopnea. A fluoroscopy performed then showed a mass in the superior mediastinum. During the week before entry, he regurgitated both solids and liquids. There had been no significant weight loss.

For seventeen years, the patient had consumed large quantities of beer, taking a minimum of 8-10 glasses a day accompanied by an inadequate diet. He had no history of abdominal swelling, jaundice or hematemesis.

Physical Examination. Blood pressure 160 85; apical rate 86; temperature 99. He was a well-developed, well-nourished male with slight orthopnea. His voice was hoarse. The skin of the face and neck had a purplish hue. The superficial veins of the neck, forehead and arms were distended. There was dilatation of the lateral thoracic and superficial epigastric branches of the internal mammary and external jugular veins. These veins appeared to fill from above. In addition, there were many venules scattered over the entire chest. The eyes revealed bluish injected sclerae, but the retinal veins were only slightly engorged. There was some A-V nicking. The throat and soft palate were injected. Auscultation of the chest showed decreased voice sounds, breath sounds and vocal fremitus above the right scapula next to the spine. There was a positive D'Espine's sign. The heart findings were within normal limits. The liver edge was felt to descend eight centimeters below the right costal margin, and there was some shifting dullness. Aside from external hemorrhoids and bilateral saphenous varicosities, the remainder of the physical examination was negative.

Laboratory. Initial laboratory studies revealed RBC 3.9 million, WBC 11,200 with 81 polys, 19 lymphs. BUN 7 mgm.%; F.B. glucose 124 mgm.%. Liver function studies revealed total serum protein 6.5 gm.%, albumin 3.2 gm.%, cholesterol 162 mgm.%, icterus index 3, thymol turbidity 2M units. Prothrombin activity 70%. BSP 50% retention at 30 minutes, 80% retention at one hour. The blood Hinton was negative. Sedimentation rate was 36 mm. hour. Venous pressure measured with a water manometer in the antecubital and femoral veins revealed the following: Right arm—347 mm., left arm—340 mm.; right thigh—130 mm., left thigh—120 mm. Decholin circulation time measured the following: Right arm—35 seconds, left arm—32 seconds; left thigh—20 seconds. (The normal venous pressure should be not over 120 mm. of water, and the decholin circulation time should not be over 16 seconds, arm to tongue.)

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* Presented before the Providence Medical Association at Providence, R. I. on October 2, 1950.

Fluoroscopy revealed a lobulated, nonpulsatile mass involving the medial half of the right upper lobe, compressing the anterior wall of the upper third of the esophagus and similarly compressing the trachea. The fluoroscopic findings were confirmed by combined bronchoscopy and esophagoscopy in which severe deviation of both the esophagus and trachea and large esophageal varices were noted. The varices were seen by barium swallow to fill almost the entire esophagus. No abnormal tissue was found at bronchoscopy, and Papanicolaou smears were negative.

The patient was given 1,740 Roentgen units to the right chest anteriorly and posteriorly over a fourteen-day period with notable subjective improvement and slight shrinkage in the size of the mass by chest film.

Anatomical Discussion

An understanding of the anatomical considerations below will aid the clinician in establishing a site of obstruction. The superior mediastinum is a narrow space bound by two unyielding walls, the thoracic vertebral column posteriorly and the sternum anteriorly. The mediastinal pleurae form the lateral boundaries. Through this space pass the esophagus, trachea, aorta, innominate veins and superior vena cava. When a space occupying lesion expands in the superior mediastinum, the structures whose walls are most collapsible are the first to become obstructed. Thus, the trachea with its cartilaginous rings and the thick-walled aorta containing blood at high pressure are relatively protected. Also, the esophagus by its position behind the trachea is defended from many anterior lesions. It is not surprising to find that the thin-walled great veins carrying blood at a low pressure are the first superior mediastinal structures to become obstructed.

The site of obstruction can be ascertained with relative certainty from the superficial collateral pathways which develop (see Figure I). Obstruction of the left innominate vein (left A in the diagram) causes blood to pass from branches of the left external jugular and left lateral horacic veins to branches of the left internal mammary vein. This plexus of dilated veins localized over the left anterior chest is a diagnostic sign of innominate vein obstruction. From there, the blood passes via the left internal mammary, intercostal, hemiazygos and azygos veins, to the superior vena cava. A similar pattern on the right side is found in right innominate vein obstruction. With obstruction above the azygos entrance (site B), a prominent venous pattern is seen on both sides of the chest. Blockage of the superior vena cava at the entrance of the azygos vein (site C) or below it (site D) prohibits this most effective route of collateral flow into the superior vena cava. Indeed, in the latter state (obstruction at site D), flow through the azygos system is reversed, carrying blood, as shown in the diagram, to the ascending lumbar, intercostal and internal mammary veins. Blood is directed from the internal mammary veins and its branches to (1) the lateral thoracic, superficial epigastric, saphenous, iliac, and inferior vena cava and (2) the superior and inferior epigastric, iliac and inferior vena cava. A small flow may eventually reach the latter vessel by the azygos and ascending lumbar veins. Inasmuch as these channels are of insufficient calibre for the load imposed upon them, venous pressure is elevated, and the circulation time from arm to tongue is slower in cases with obstruction above the azygos entrance than in cases with obstruction at or below it. Clinically, superior vena cava obstruction at, or below, the azygos vein is diagnosed by the pattern of dilated veins extending from the lateral thoracic walls to the lower abdomen. To differentiate superior from inferior vena cava obstruction, which also gives a superficial venous pattern, segments of two of the dilated veins—one above and one below the umbilicus—are collapsed by spreading the examining thumb and index finger along their course. One finds that both veins fill from above in the former condition while both fill from below in the latter.

One of the earliest signs of superior vena cava obstruction is the appearance of numerous small, purple, isolated venules distributed over the chest wall, and edema of the eyelids. Later, venous engorgement and edema of the neck, head and arms appear. The symptoms which usually appear later —dyspnea, hoarseness, dysphagia, chest pain, headache and drowsiness—are due to damage of local structures, impaired venous flow and to increased venous pressure in the head. A suspected diagnosis is confirmed by finding elevated venous pressure in the arms with a normal value in the femoral veins.

Once the clinician is convinced that this syndrome is present, a strenuous effort should be made to learn its cause. A list of possibilities is shown in Table I—modified from charts of McIntire and Sykes.[1] They comprise an average of figures from the world literature since 1904. About one-third of the cases are caused by primary malignancy, one-quarter by aortic aneurysms and one-fifth by chronic mediastinitis. The remaining one-fifth are the result of an assortment of uncommon causes.

TABLE I

Etiology of Cases Confirmed by Postmortem	*Distribution*
CHRONIC MEDIASTINITIS	20.7%
(Traction or compression of superior vena cava by scar tissue)	
a. Tuberculosis	36.7%
b. Syphilis	40.0%
c. Etiology undetermined	23.3%

PRIMARY MALIGNANT TUMORS 33.0%

a. Tumor of bronchus or lung 39.6%
b. Malignant lymphoma (including Hodgkin's disease) 25.0%
c. Sarcoma 10.4%
d. Tumor of thymus 10.4%
e. Leukemia 6.25%
f. Tumor of esophagus 2.09%
g. Chorionepithelioma 2.09%
h. Unclassified 4.17%

AORTIC ANEURYSM 26.9%

MISCELLANEOUS 19.4%

a. Propagating thrombi from periphery
b. Local phlebitis with thrombosis
c. Metastatic cancer to thoracic organs
d. Tumor tissue spilling into tributaries of superior vena cava
e. Actinomycosis
f. Tuberculous phlebitis

Of great importance in causing superior vena cava obstruction are the antero-mediastinal and the right laterotracheal chain of nodes into which drain the lymphatics of the lower trachea, right bronchi, and most of the right lung. These nodes lie chiefly in, or about, a triangle formed by the azygos vein, the right vagus nerve, and the superior vena cava. When enlarged from infection or malignancy, these nodes are a frequent cause of right innominate vein and superior vena caval obstruction.[1] Chronic mediastinitis often cannot be differentiated from a tumor except by an exploratory operation or autopsy. In this condition is found a dense mass of collagenous tissue binding the surrounding structures and constricting the superior vena cava. A history of severe tracheobronchial or pulmonary infection in many of these patients suggests that a chronic purulent lymphadenitis may have been the initiating factor.

Treatment is essentially that of the primary pathology. If a mass is present which does not appear to be an aneurysm, x-radiation may be tried as some temporary relief can be obtained should it be a lymphoma. If this fails, nitrogen mustard has been of benefit in some anaplastic carcinomas, as well as lymphomas, and is worthy of trial. A course of A. C. T. H. or Cortisone should be considered for cases of lymphoma.[12] Chronic fibrous mediastinitis, especially if there is a history of antecedent severe infection or chest trauma, should be suspected, and mediastinotomy with lysis of adhesions has been recommended if symptoms are severe and progressive.[10] Symptomatically, phlebotomy is of benefit. Improvement from treatment can be ascertained objectively by measuring the venous pressure at intervals in both arms and thighs. It is to be expected that with the advent of antibiotics the incidence of chronic mediastinitis will continue to decrease during the next decade. Once it appears, occasional patients may live for several years with slowly increasing superior vena caval obstruction. The prognosis in cases with aneurysms and malignancy (comprising in all about 70%) is poor. Twenty-two of twenty-four cases of chronic mediastinitis died in Ochsner series.[11]

Case Discussion

The case under consideration presented the following clinical features of the superior mediastinal syndrome: the history of cough, hoarseness and dysphagia, the cyanotic hue of the face, neck, chest and arms, the numerous thoracic dilated venules and large external jugular-internal mammary anastomoses with an *elevated antecubital venous pressure*. An obstruction at, or below, the entrance of the azygos vein into the superior vena cava was indicated by the distended lateral thoracic and superficial epigastric veins which filled from above.

The second diagnosis of Laennec's cirrhosis was suggested by the history of inadequate diet and heavy alcoholic intake, by severe hepatomegaly and abnormally high BSP retention. Portal hypertension must have been present because of esophageal varices and evidence of mild ascites. The etiologic factors in esophageal varix formation from portal hypertension are weak, thin, supporting tissues, excessive movement, and trauma from a passing bolus of food.[8] To these factors should be added increased venous pressure and stasis, as would be caused by azygos vein obstruction, since the latter is the most important outlet of blood from the esophageal veins into the superior vena cava. Esophageal varices from azygos vein obstruction were not mentioned by Carlson[9] in his experimental obstruction of the superior vena cava in dogs, nor was any record found of esophageal varices in autopsy protocols of cases with mediastinal syndrome reviewed. Competent valves in the esophageal veins should prevent collateral flow reverse to that seen in portal hypertension.

Thus, in this case, the sites of circulatory obstruction were determined clinically and on the basis of the above reasoning, massive esophageal varices were predicted. Barium swallow followed by esophagoscopy confirmed their presence. The rapid progression of symptoms, the negative Hinton, the nonpulsatile nature and outline of the mass seen at fluoroscopy, the shrinkage of the mass following x-radiation, all point to a malignant tumor as the cause of obstruction rather than an aneurysm or chronic mediastinitis.

Summary

The pertinent literature, anatomy, symptomatology, etiology, treatment and prognosis of the superior mediastinal syndrome are briefly reviewed. A case having the typical features of this syndrome is presented because of the unusual feature of associated portal hypertension with esophageal varices. A discussion of the probable circulatory changes

continued on next page

produced by an association of the two obstructed venous systems in this case is discussed on the basis of clinical data, inasmuch as postmortem material is not available.

Bibliography

[1] McIntire, F. T., & Sykes, E. M., Jr., Obstruction of the Superior Vena Cava: A Review of the Literature and Report of Two Personal Cases; *Annals of Internal Medicine*, Vol. 30, 925, 1949.

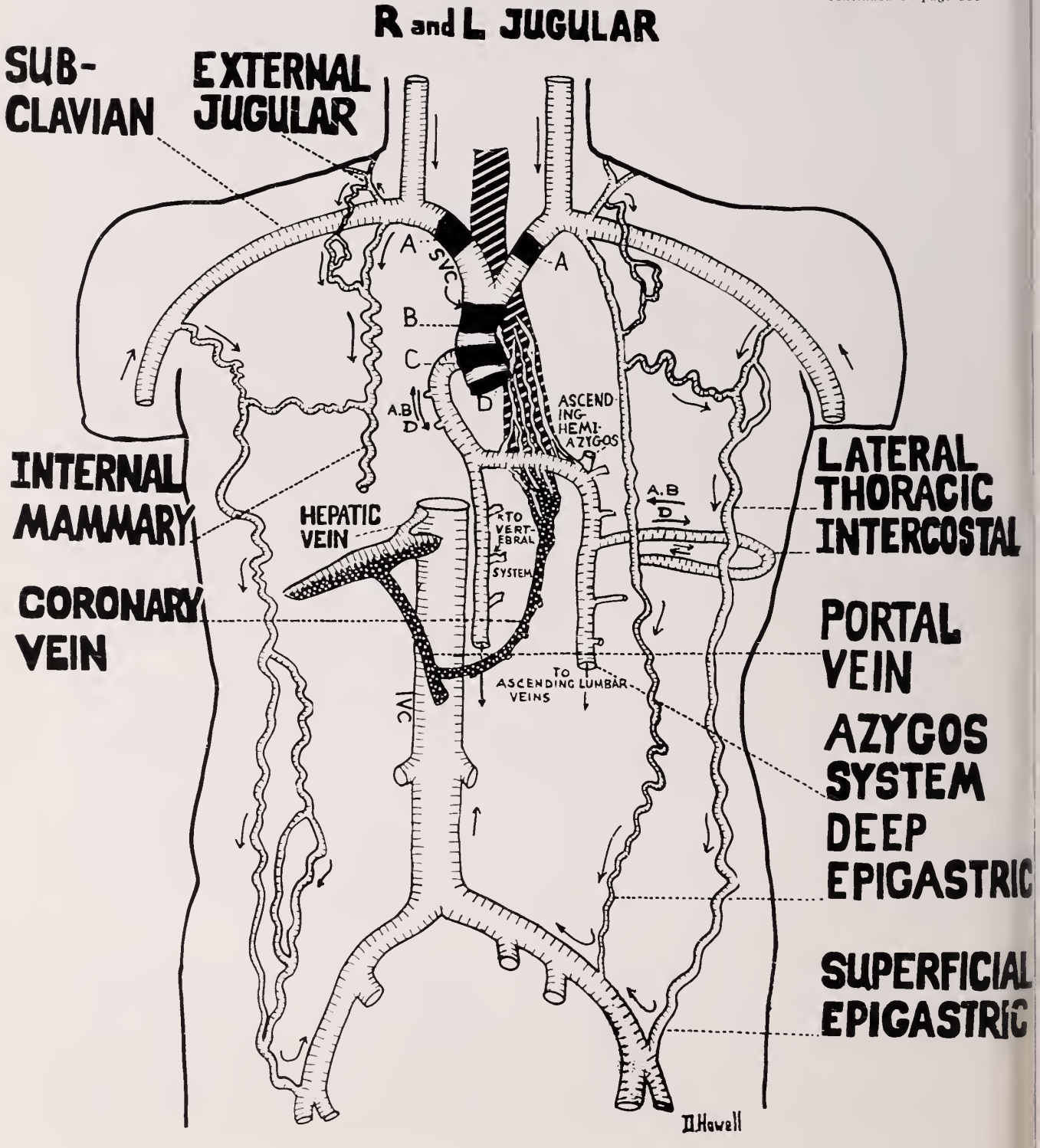
[2] Osler, William: On Obliteration of the Superior Vena Cava; *Bull. Johns Hopkins Hosp.*, Vol. 14, 169, 1903.

[3] Fischer, Julius: Uber Verengerung Und Verschlieszung Der Vena Cava Superior, Inaug. Dissert., Halle, 1904.

[4] Rauth, Alfred: Beitrage Zur Kasuistik Der Kompression Der Cava Superior, Inaug. Dissert., Giessen, 1911.

[5] Dana, H. W., McIntosh, R.: Obstruction of the Superior Vena Cava by Primary Carcinoma of the Lung, *Am. J. Med. Sci.*, Vol. 163, 411, 1922.

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WHY NOT THE AMA?

The action of the board of regents of the American College of Surgeons in requesting, last Spring, that the American Hospital Association consider the transfer of the program of hospital standardization from the College to the AHA on the basis that, when properly operated, it was an expensive service for the surgeons to finance unaided, touched off a nationwide discussion.

Happily the solution was reached at Boston when the College of Surgeons met there in annual conclave late in October. At that time the surgeons voted unanimously to continue the hospital standardization program of the College, but the action was not interpreted to mean that further consideration of proposals for the participation of other interested agencies in this program. The action did make clear that the College would continue its sponsorship and would consider no proposal which will not insure its continuation in the best interests of the public.

Elsewhere we reprint in this issue the editorial on "Hospital Standardization" written by Dr. George F. Lull, secretary and general manager of the AMA for the publication *Modern Hospital,* and which appeared in the November issue of that journal. This editorial, written prior to the action of the College of Surgeons in Boston, advances some worthwhile suggestions for the solution of the hospital standardization program that the College of Surgeons has supported with its own funds since 1916.

Undoubtedly the question will be the subject of debate in medical circles for many months ahead. But what has never been explained in any reports that have come to our attention regarding this situation is why the College of Surgeons did not bring their problem to the American Medical Association in the first place. Instead, the contact was with the American Hospital Association which went ahead and voted, through its House of Delegates at their September session, to set up a hospital standardization program, preferably taking over that of the College of Surgeons.

Those in the hospital field are the first to deny any interest in lay control of medical practice. Yet the facts stand that the action taken by the American Hospital Association would mean that the hospitals, with a preponderance of lay administrators, would act as judge and jury in medical matters, and this position would appear to be further advanced by the fact that the proposed 25-member commission to establish the hospital classifications would provide for only six physicians.

We can hardly blame the American Hospital Association for accepting the invitation to take over the standardization program when overtures were made to it. We can only raise our voice in criticism at the action of the board of regents of the College of Surgeons for not turning to their own medical organization—the American Medical Association—for help and guidance on their problem which was fundamentally a financial one.

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POSTGRADUATE EDUCATION

This Fall has started off with a bang for Rhode Island physicians. They have had two instructive and edifying series of lectures presented to them, even before the regular winter season has started.

The Third Annual Cancer Conference presented by the Cancer Committee of the Rhode Island Medical Society on October 18, was, in the estimation of every one with whom we have consulted, a remarkable symposium. It is unfortunate that there was not a larger audience present. We know that cancer is not to the average medical man the most interesting of subjects, but it should be.

It used to be said that one who knew syphilis knew all medicine. That is almost as true of cancer. Its manifestations are protean. One of the participants in the program, who had travelled a long way to get here, remarked that he would have been glad to come to this meeting even if he had not been going to take a part in it.

Dr. Scannell, of the Massachusetts General Hospital, continued his discussion of Cancer of the Lung, which he had started last year. We are pleased to say that we intend to print this in a later edition of our Journal. Dr. Leiter of Bethesda initiated us into the tremendous intricacy of experiments in cancer work down there. Oliver Cope told us about the new building at the Massachusetts General Hospital, filled with the most expensive apparatus manned by highly trained physicists, and gave us a necessarily sketchy but stimulating report on the use of radioactive isotopes.

Dr. Francis S. Moore, who was recently appointed Professor of Surgery at Harvard, gave an illuminative and discriminating talk on that, at present, doleful subject, cancer of the stomach. One must admit that at present progress in the treatment of this disease is advancing slowly, if at all. Such studies as Dr. Moore and his associates are making and their philosophical analysis of the problem at least show us what not to do and outline more intelligent procedures.

The motion picture on breast cancer appeared to be chiefly the work of Dr. Haagensen of the Presbyterian Hospital in New York. Many of us have seen and heard him demonstrate this subject. Dr. Haagensen is one of our very best teachers. We were greatly satisfied with the presentation rendered by Dr. Elvidge, who came all the way from the Montreal Neurological Institute, and the large series of x-rays he demonstrated were very interesting. His use of angiograms was particularly striking. Drs. Dargeon and Catlin of the Memorial Hospital in New York gave us demonstrations on their restrictive study of tumors in children and cancer of the oral cavity, which were of the high grade that we expect from that institution. It is unusually interesting to have Dr. Meyer carry on from where his famous father, Dr. Willy Meyer, left off in cancer of the breast. Altogether the limited group of doctors who attended this meeting must have felt that they were privileged people.

Lectures on the Diagnosis and Treatment of Heart Disease, sponsored by the Rhode Island Department of Health and arranged for by Dr. Marshall N. Fulton and his Committee on Postgraduate Medical Education, pretty well covered the broad modern knowledge of heart disease. Every speaker was outstanding in his knowledge of the section which he treated; and what is fully as important to the audience, they knew how to impart their knowledge in an interesting manner. In our next issue we will have an article summarizing the contents of these six lectures. It will pay you to study this carefully.

AMA DUES

During the year the Society has undertaken the collection of membership dues for the American Medical Association. Any physician who has overlooked the payment of his dues is cautioned to clear his indebtedness immediately in order that he may not lose his affiliation with the national organization.

And for the benefit of members of the Society who failed to note the previous announcement, we repeat that the AMA dues for 1951 will be $25 for which will be included a subscription to the Journal of the AMA which presently sells at $12. Thus, allowing for the journals to be received during the year, the AMA member will actually be paying $13 as dues in 1951.

Fellowship in the Scientific Assembly has been preserved but the dues have been reduced from $12 to $5 per year. Fellows will be permitted to elect to take a special journal in lieu of the Journal of the AMA which they would ordinarily receive as members.

GENERAL PRACTITIONER AWARD

THE Rhode Island Medical Society has not furnished a general practitioner of the year, but the recipient of the 1950 American Medical Association's gold medal "for exceptional service by a general practitioner" has always been just over the line from us. We imagine that the people living in Seekonk or Rehoboth most of the time must almost feel themselves Rhode Islanders.

Dr. Dean Sherwood Luce of Canton, Massachusetts, has just received this award, and Canton is about as far away as he ever got from us. He was born only 74 years ago in Holliston, right over the state line. His father was a Yankee ship owner and sea captain who lost his ship and barely saved himself when his boy was only six years old. Then he retired and opened a store on Martha's Vineyard. People who know the Cape and Islands know that the Luces used to be mighty thick around there.

Dr. Luce then went to Phillips Andover, one of the oldest, most typical New England schools, but he had to quit to run the store on the Vineyard for a while. Then he went to Harvard Medical School, tending to the family business on the week-ends. After his interneship he settled down in Canton, and he has been doing general practice ever since. Just to be consistent, he married a Canton girl who used to spend summers on the Vineyard. To keep up the medical tradition in the family, his only daughter, Mary, has become a biologist at the Lahey Clinic.

He has been affluent from the beginning of his practice; he did $1100 of it the first year. That meant a great deal of hustling at 50 cents for an office call and deliveries at $8, but with eggs at a cent apiece, and milk at 5 cents a quart, one could live pretty well on that income.

Dr. Luce did not wish us to stress the financial aspects too heavily because he says, "I never made a lot of money out of it, and I never intended to."

He is a Councillor of the Massachusetts Medical Society and is Editor-in-Chief of a smart paper run by the Norfolk District Medical Society. He had previously been named the outstanding general practitioner of the year by his own Massachusetts Medical Society.

The medical profession of Rhode Island felicitates Doctor Luce on the distinguished award that has been bestowed upon him, and through him upon all general practitioners of the country. We are particularly pleased that the physician of the mid-century should be a New England neighbor.

HOSPITAL STANDARDIZATION

Since 1918 the American College of Surgeons, without assistance from other organizations within the profession, has sponsored a hospital standardization program, the purpose of which was "to create in the hospital an environment which will assure the best possible care of the patient." It has been recognized by the medical profession and hospital group alike that the College of Surgeons through this program has made a significant contribution to American medicine and to the field of hospital administration as well. The cost of the program to date has been estimated at approximately $2,000,000, a financial burden which has been borne solely by fellows of the College.

Recently, the American College of Surgeons explored the possibility of conducting the program in cooperation with or by other interested organizations. The American Hospital Association expressed its interest in assuming responsibility for the program under its own aegis, and at its recent annual meeting in Atlantic City authorized an increase in dues of member hospitals for this purpose. A plan had been proposed which would create a 25 member commission within the American Hospital Association to include six members of the medical profession, six hospital administrators and 13 individuals with outstanding records as hospital trustees. The six-man medical committee was to have included three representatives of the American College of Surgeons and three of the American College of Physicians. To this committee was delegated the responsibility for formulating standards for those aspects of the hospitals' activities which were considered to be primarily of a professional nature. The determination as to which areas were primarily professional and which were administrative was, however, made the responsibility of the commission as a whole.

The American Medical Association, being of the opinion that a program of hospital standardization, such as had been proposed, would directly affect standards of medical practice in hospitals, requested that action by the American Hospital Association in establishing the standardization program be delayed until all aspects of the problem could be given careful consideration. Acting through its board of trustees, the association entered into discussion with the American College of Surgeons and the American Hospital Association in the hope that a cooperative plan could be developed which would eliminate a dual standardization program with its consequent duplication of effort and needless expenditure of funds.

The three groups have been holding meetings, the last of which was also attended by representatives of the American College of Physicians, in an attempt to clarify the position of the several organizations involved. Much progress has been made in working toward the objective, a plan in which the best interest of the public, the hospitals and the profession are all considered. There has been no disagreement over the principle that the setting of standards for the professional aspect of the hospital would lie with members of the medical profession. The American Medical Association has not felt, however, that this principle was adequately safeguarded under the plan originally proposed, which would set up a commission as an agency of the American Hospital Association.

As expressed in discussions held during the past several weeks, the American Medical Association is prepared at this time to consider favorably one of the following alternate plans:

1. Continued sponsorship of the hospital standardization program by the American College of Surgeons, with financial support by the American Medical Association and other organizations directly concerned.

continued on next page

2. Establishment of an individual commission, board or committee, with representatives from the American College of Surgeons, American College of Physicians, American Hospital Association and the American Medical Association, which would be charged with the responsibility of formulating standards for administrative and professional aspects of hospital activities, for conducting a unified inspection program for approval of hospitals which meet these standards; the financing of the cost of the commission, including the field inspecting service, would be borne on a proportionate basis by member organizations.

3. Transfer of the standardization program to the Council on Medical Education and Hospitals of the American Medical Association, with a unified inspection program conducted in connection with the field service now administered by the council in the approval of hospitals for intern and resident training. (In general surgery the council presently conducts hospital surveys in behalf of the American College of Surgeons, the American Board of Surgery and the A.M.A.)

Pending outcome of present negotiations, we have been advised that the American College of Surgeons will continue its present program.

It is our hope that the program so successfully carried out by the college over the last 30 years can be expanded under a plan acceptable to all organizations concerned, and that such a program will prove even more effective in bringing about the results toward which the several organizations are striving, that of better patient care.

—George F. Lull, M.D.

Reprinted from The Modern Hospital, November 1950

RHODE ISLAND VOLUNTARY ADVISORY COMMITTEE FOR THE SELECTION OF DOCTORS, DENTISTS, AND ALLIED SPECIALISTS

Dr. Howard Rusk, Chairman of the National Advisory Committee to Selective Service on the Selection of Doctors, Dentists and Allied Specialists, has appointed a Rhode Island Voluntary Advisory Committee for the Selection of Doctors, Dentists and Allied Specialists. Similar committees have been appointed in all other states of the United States. The members of the Rhode Island committee appointed by Dr. Rusk are Herman A. Lawson, M.D., Chairman; Edward A. McLaughlin, M.D., and Harold J. Pearce, D.M.D.

The Chairman is authorized to appoint additional members to the committee, and to appoint sub-committees to deal with problems concerning various areas or communities and different professions and specialties concerned in provisions of Public Law 779, 81st Congress. These appointments are subject to approval and confirmation by the National Committee.

The following sub-committee for the selection of physicians has been appointed:

Frederic J. Burns, M.D., Providence
Morgan Cutts, M.D., Providence
Waldo Hoey, M.D., Providence
Frank B. Littlefield, M.D., Providence
David Wright, M.D., Providence
Samuel Adelson, M.D., Newport
Earl F. Kelly, M.D., Pawtucket
Leo Dugas, M.D., Woonsocket
Whitman Merrill, M.D., Coventry
Samuel Nathans, M.D., Westerly

The following sub-committee for the selection of dentists has been appointed:

Harold J. Pearce, D.M.D., Providence
Allyn Sullivan, D.M.D., Providence
Morris Biderman, D.M.D., Providence
Edgar Bessette, D.M.D., Providence
Michael Messore, D.M.D., Providence
William MacIntosh, D.M.D., Providence
Charles Heaton, D.M.D., Providence
Simon Ozarin, D.M.D., Newport
Archie Albert, D.M.D., Pawtucket
James Colgan, D.M.D., Pawtucket
Bernard Friedman, D.M.D., Newport
Gerard Archambault, D.M.D., Warwick
Charles Berard, D.M.D., Woonsocket
Edward Radlo, D.M.D., Pawtucket
Joseph Serra, D.M.D., Westerly

A sub-committee for the selection of Allied Specialists will be appointed. The designation "Allied Specialist" is intended to include, but not to be limited to, veterinarians, pharmacists, optometrists, and osteopaths.

The primary function of the Advisory Committee is to render advice and aid to the Selective Service System in Rhode Island in the orderly selection of doctors, dentists and others so that the essential health services of hospital and other health agencies in the state will not be adversely affected. The essential needs of all communities are to be protected in all possible ways. The committee has no function in relation to those individuals who are members of the organized reserve of any of the Armed Forces; such persons are not required to register with Selective Service, and are subject to decisions of that branch of the Armed Forces to which they belong.

The National Advisory Committee have stated that "in considering essentiality generally, three factors are primary: (1) The medical and health needs of the community, e.g., availability of physicians in sparsely settled communities where there is only one physician available; and essential public health services; (2) critical research; (3) professional teaching."

Bronchial Relaxant . . .
Antiallergic . . .
Expectorant . . .



Combined in a New Compound for Cough Control

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COMPOUND

incorporates these important compounds for the treatment of cough:

AMINOPHYLLIN (SEARLE) . . . *for bronchial relaxation;*

DIPHENHYDRAMINE (SEARLE) . . . *for antiallergic efficacy;*

POTASSIUM IODIDE . . . *for expectorant action—in a pleasant-tasting syrup base.*

SEARLE
RESEARCH IN THE SERVICE OF MEDICINE

SURVIVAL UNDER ATOMIC ATTACK

Reprinted from the Official U.S. Government Booklet Issued by the Executive Office of the President, National Security Resources Board, and the Civil Defense Office

KILL THE MYTHS

Atomic Weapons Will Not Destroy the Earth

ATOMIC BOMBS hold more death and destruction than man ever before has wrapped up in a single package, but their over-all power still has very definite limits. Not even hydrogen bombs will blow the earth apart or kill us all by radioactivity.

Doubling Bomb Power Does Not Double Destruction

Modern A-bombs can cause heavy damage 2 miles away, but doubling their power would extend that range only to 2½ miles. To stretch the damage range from 2 to 4 miles would require a weapon more than *8 times* the rated power of present models.

Radioactivity Is Not the Bomb's Greatest Threat

In most atom raids, blast and heat are by far the greatest dangers that people must face. Radioactivity alone would account for only a small percentage of all human deaths and injuries, except in underground or underwater explosions.

Radiation Sickness Is Not Always Fatal

In small amounts, radioactivity seldom is harmful. Even when serious radiation sickness follows a heavy dosage, there is still a good chance for recovery.

SIX SURVIVAL SECRETS FOR ATOMIC ATTACKS

Always *Put First Things First and*
Never *Lose Your Head and*

1. TRY TO GET SHIELDED
   If you have time, get down in a basement or subway. Should you unexpectedly be caught out-of-doors, seek shelter alongside a building, or jump in any handy ditch or gutter.
2. DROP FLAT ON GROUND OR FLOOR
   To keep from being tossed about and to lessen the chances of being struck by falling and flying objects, flatten out at the base of a wall, or at the bottom of a bank.
3. BURY YOUR FACE IN YOUR ARMS
   When you drop flat, hide your eyes in the crook of your elbow. That will protect your face from flash burns, prevent temporary blindness and keep flying objects out of your eyes.
4. DON'T RUSH OUTSIDE RIGHT AFTER A BOMBING
   After an air burst, wait a few minutes, then go help to fight fires. After other kinds of bursts, wait at least 1 hour to give lingering radiation some chance to die down.
5. DON'T TAKE CHANCES WITH FOOD OR WATER IN OPEN CONTAINERS
   To prevent radioactive poisoning or disease, select your food and water with care. When there is reason to believe they may be contaminated, stick to canned and bottled things if possible.
6. DON'T START RUMORS
   In the confusion that follows a bombing, a single rumor might touch off a panic that could cost your life.

FIVE KEYS TO HOUSEHOLD SAFETY

1. STRIVE FOR "FIREPROOF HOUSEKEEPING"
   Don't let trash pile up, and keep waste paper in covered containers. When an alert sounds, do all you can to eliminate sparks by shutting off the oil burner and covering all open flames.
2. KNOW YOUR OWN HOME
   Know which is the safest part of your cellar, learn how to turn off your oil burner and what to do about utilities.
3. HAVE EMERGENCY EQUIPMENT AND SUPPLIES HANDY
   Always have a good flashlight, a radio, first-aid equipment and a supply of canned goods in the house.
4. CLOSE ALL WINDOWS AND DOORS AND DRAW THE BLINDS
   If you have time when an alert sounds, close the house up tight in order to keep out fire sparks and radioactive dusts and to lessen the chances of being cut by flying glass. Keep the house closed until all danger is past.
5. USE THE TELEPHONE ONLY FOR TRUE EMERGENCIES
   Do not use the phone unless absolutely necessary. Leave the lines open for real emergency traffic.



Priscoline

A potent vasodilator effective by mouth...

Priscoline hydrochloride "has a definite place in the armamentarium of drugs... particularly in the field of *peripheral vascular disease*, or for conditions of visceral pain due to vascular spasm. Presumably the drug can be used to a great advantage in those cases in which sympathectomy would be advantageous. . . . It can also be used as a substitute for paravertebral sympathetic block."[1]

"Priscoline per se appeared to slow down progression of the disease and produce symptomatic benefits in 88 per cent of 25 patients with early proliferative and degenerative *arthritis* involving peripheral joints."[2]

In doses of 25 to 75 mg., administered either orally or parenterally, Priscoline "usually is tolerated with few side effects."[3]

Comprehensive literature on request.

1. Rogers, Max P.: J.A.M.A., May 21, 1949
2. Wyatt, Bernard L.: Ann. West. Med. & Surg., Aug. 1949
3. Grimson, Marzoni, Reardon & Hendrix: Ann. Surg., 127:5, May 1948

PRISCOLINE, Tablets of 25 mg.; 10 cc. Multiple-dose Vials, each cc. containing 25 mg.

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

PRISCOLINE (brand of benzazoline) Trade Mark Reg. U.S. Pat. Off. 2/1567M

Multiple Vitamin Deficiencies

". . . Deficiency diseases clinically evident are usually associated with additional tissue deficiencies of nutrients not yet clinically manifest." (Jolliffe, Tisdall & Cannon: Clinical Nutrition, New York, Hoeber, 1950, p. 633-634.)

THERAGRAN

THERAPEUTIC FORMULA VITAMIN CAPSULES SQUIBB



—supplies all of the vitamins indicated in mixed vitamin therapy in the clinically proved, truly therapeutic "practical formula"* recommended by Jolliffe.

Each Theragran Capsule gives your patient:

Vitamin A	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine hydrochloride	10 mg.
Riboflavin	5 mg.
Niacinamide	150 mg.
Ascorbic acid	150 mg.

Bottles of 30, 100, and 1000

* *Thiamine content raised to 10 mg.*

for true vitamin therapy . . .

specify **THERAGRAN®**

SQUIBB

AMA DONATES $500,000 TO MEDICAL SCHOOLS

THE American Medical Association has taken the leadership in providing private support for hard-pressed medical schools.

By unanimous action of the Board of Trustees, it has appropriated $500,000, as an endowment "without strings," to be given the medical schools as a nucleus for a nationwide fund to be raised from nonpolitical sources. This is in addition to the quarter of a million dollars—$285,000 for 1951—which the Association has spent annually for years, through its Council on Medical Education and Hospitals and other departments, to advance medical education.

The half million dollar contribution comes from the Association's national education campaign fund. This means that every doctor, as he puts up his $25, can know that a considerable share of it goes to insure training, and better training, for youngsters setting out on the hard road he has traveled.

Dramatic and far-reaching as it is, the action is hardly a new departure. The Association was founded more than a century ago by men who felt that their own integrity was challenged so long as unqualified men could call themselves "M.D."

Action of the Board came in swift response to the challenge made by President E. L. Henderson to the House of Delegates at the Cleveland session this month, that the profession take the initiative in raising nonpolitical funds for medical education rather than seek federal subsidy. The thought behind it, put not elegantly but perhaps accurately, is that people who feed at the federal trough must trot to the tune of whatever caller is currently established on the Potomac. And that is no situation to foster freedom of education and research.

"American medicine feels very strongly that it should not seek federal aid for medical schools until all other means of financing have been exhausted," said Chairman Louis H. Bauer of the Board. "The Board of Trustees announced its belief that funds for this purpose could be obtained from private sources—and as practical evidence of our sincerity of purpose, this appropriation has been made as the nucleus of a fund which we hope will be augmented by contributions from many other sources.

"The Board hopes that this action will become a stimulus to other professions, industries, businesses, labor groups and private donors. The American Medical Association urges all its members to contribute individually to this cause, and we hope that doctors will take the lead in securing contributions from other sources."

INSURANCE EXAMINATION FEES

The Rhode Island Medical Society two years ago was one of the prime movers in instigating national action relative to the adjustment of the schedule of fees of life insurance companies paid to physicians for examinations and for attending physician reports. The schedule had not been altered for fifty years until this action was initiated.

The Bureau of Medical Economic Research of the American Medical Association has submitted the list of companies as noted below that have adjusted their fees upward, in general about 50%.

Aetna
American General
Bankers Life
Columbian National
Connecticut General

Connecticut Mutual
Continental Assurance
Control Life
Equitable Assurance, N. Y.
Equitable of Iowa

Fidelity Mutual
Franklin Life
Great Southern
Guardian
Home Life

Jefferson Standard
Life Insurance of Vermont
Lincoln National
Manhattan
Maccabees

Metropolitan
Mutual Life, New York
Mutual Trust
National Life & Accident
National Life, Vermont

New England Mutual
New York Life
Occidental
Ohio National
Pacific Mutual

Pan American
Phoenix
Pilot Life
Provident Mutual
Prudential

Security Mutual
Southland Life
Southwestern
Standard, Oregon
State Mutual

Sun Life
Travelers
United Life & Accident

104TH
ANNUAL MEETING

PROVIDENCE
MEDICAL ASSOCIATION

Monday, January 8th, 1951

AT THE

MEDICAL LIBRARY, 8:30 p. m.

Multiple Vitamin Therapy

". . . Patients fare much better when [the deficiencies] are treated simultaneously. . . . Convalescence is delayed when one gives only one vitamin at a time . . ." (Spies & Butt in Duncan, G. G.: Diseases of Metabolism, ed. 2, Philadelphia, Saunders, 1947, p. 504.)

THERAGRAN
THERAPEUTIC FORMULA VITAMIN CAPSULES SQUIBB



Each Theragran Capsule gives your patient:

Vitamin A ..... 25,000 U.S.P. units
Vitamin D ..... 1,000 U.S.P. units
Thiamine hydrochloride .... 10 mg.
Riboflavin ..... 5 mg.
Niacinamide ..... 150 mg.
Ascorbic acid ..... 150 mg.

Bottles of 30, 100, and 1000

When you want truly therapeutic dosages— specify THERAGRAN®

SQUIBB

DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

A business meeting of the Pawtucket Medical Association was held at the Nurses Auditorium of Memorial Hospital on October 19, 1950.

The meeting was called to order by President James P. Healey at 12 noon. The minutes of the September meeting were read by the secretary and accepted.

A resolution drawn up by our committee on the death of Dr. James L. Wheaton was read by the secretary. Dr. Fox made the motion which was passed to adopt this resolution, engross it on our records, and send a copy to Dr. Wheaton's family.

Samples of newspaper advertising and a newspaper mat from the R. I. Medical Society as part of the national campaign against compulsory health insurance were introduced. Dr. Melucci made the motion which was carried that the mat "It's a Gift" be used as advertising by the Pawtucket Medical Association and expenditure up to $50 be allowed. Half of such costs will be borne by the R. I. Medical Society.

Dr. Mara, chairman of the Diabetes Committee, asked all physicians to cooperate in the testing of urines during Diabetes week, November 12-18, 1950, and to send in reports on the cards provided.

Dr. Mara reported on a meeting of the Physicians Service Corporation. Approximately 110,000 members have bought the plan under the group basis. Contracts for individuals are being studied for revision.

Dr. Ferguson asked whether any action was being taken by the R. I. Medical Society on physicians going into the services. None has been taken as far as is known.

The meeting adjourned at 12:35 p. m.

Attendance 15.

Respectfully submitted,

HRAD ZOLMIAN, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular meeting of the Kent County Medical Society was called to order by the president at 9:15 p. m., October 17, 1950.

The minutes of the previous meeting were read and approved.

Dr. Harold Collom of the Hospital Committee read a rough draft of the proposed by-laws for the staff of the Kent County Memorial Hospital. These by-laws were discussed by the members of the society. Dr. Merrill's motion was passed that these by-laws be mimeographed and sent to each member of the society and a special meeting of the society be held in two weeks for approval of the by-laws.

The meeting adjourned at 11:15 p. m.

Respectfully submitted,

GEORGE L. YOUNG, M.D., *Secretary, pro-tem.*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 6, 1950. The meeting was called to order by the President, Dr. Frank W. Dimmitt, at 8:30 p. m.

By consent of the members present the Secretary omitted the reading of the minutes of the preceding meeting.

The Secretary read a communication from the Audubon Society of Rhode Island regarding a series of lectures to be given under the auspices of that society.

The Secretary read a communication from the State Medical Society relative to preliminary plans for disaster planning in the greater Providence area through the Associations committee on disaster and the state Society committee on national emergency medical service.

Dr. Dimmitt urged support by the members of the diabetes detection campaign. He called upon Dr. Louis I. Kramer, chairman of the State Society's committee on diabetes, who spoke briefly about the campaign to be conducted from November 12-18.

The President announced that the Association would not meet the first Monday in December, and instead would meet jointly with the Rhode Island Medical Society at Woonsocket on December 13. He read the program for this meeting, and he urged the attendance of all members.

The Secretary reported that the date for the January meeting, in accordance with the by-laws, would be January 1. He therefore moved that the Association's annual meeting be held on Monday, January 8, instead of Monday, January 1, 1951. The motion was seconded and adopted.

continued on page 674



THROAT SPECIALISTS REPORT

ON 30-DAY TEST OF CAMEL SMOKERS...

"Not one single case of throat irritation due to smoking Camels!"

Yes, these were the findings of throat specialists after a total of 2,470 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels —for 30 consecutive days.



HARRY SOUTHWELL, lawyer, is one of hundreds, coast to coast, who made the 30-Day Test of Camel Mildness under the observation of throat specialists.

ACCORDING TO A NATIONWIDE SURVEY:

More Doctors smoke Camels

THAN ANY OTHER CIGARETTE

Yes, doctors smoke far pleasure, too! In a nationwide survey, three independent research organizations asked 113,597 doctors whot cigorette they smoked. The brand named most was Camel.

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

proof of performance
shown by
proof of preference



*Sealy's Accepted**
Orthopedic Mattress now

WORLD'S LARGEST SELLING ORTHOPEDIC MATTRESS

To patients suffering from morning backache due to sleeping on an inferior mattress or improperly fitted bedboards, you may suggest the Sealy Orthopedic, with confidence.

*Accepted for advertising in the Journal of the American Medical Association, Sealy's Orthopedic is now the most widely used mattress of its type in the world. Since it is correctly *firm* it insures proper sleeping posture, gives natural support and complete comfort, too. For patients bothered by "low" morning backache, possibly caused by sleeping on a flabby mattress or make-shift bedboard, you may mention the Sealy Orthopedic *knowing* it is giving helpful relief in steadily increasing thousands of cases.

ADVERTISED IN AMERICAN MEDICAL ASSOCIATION PUBLICATIONS

Sealy

SEALY MATTRESS COMPANY
79 Benedict Street Waterbury, Connecticut

PROVIDENCE MEDICAL ASSOCIATION

continued from page 672

The President introduced as the first speaker of the evening Dr. C. J. Bellavance, resident of Rhode Island Hospital, who, with Dr. Richard F. Mulroy, assistant resident, in the department of orthopedics at Rhode Island Hospital, presented a case report on "Tetanus."

Dr. Bellavance presented a case of tetanus who presented trismus and temperature of 100 on the first day. The second day, neck rigidity set in. The day following, his temperature rose to 107 rectally with twitches of the extremities, but no convulsions. The spine and abdominal muscles became rigid. From the 5th day on, the temperature gradually came down.

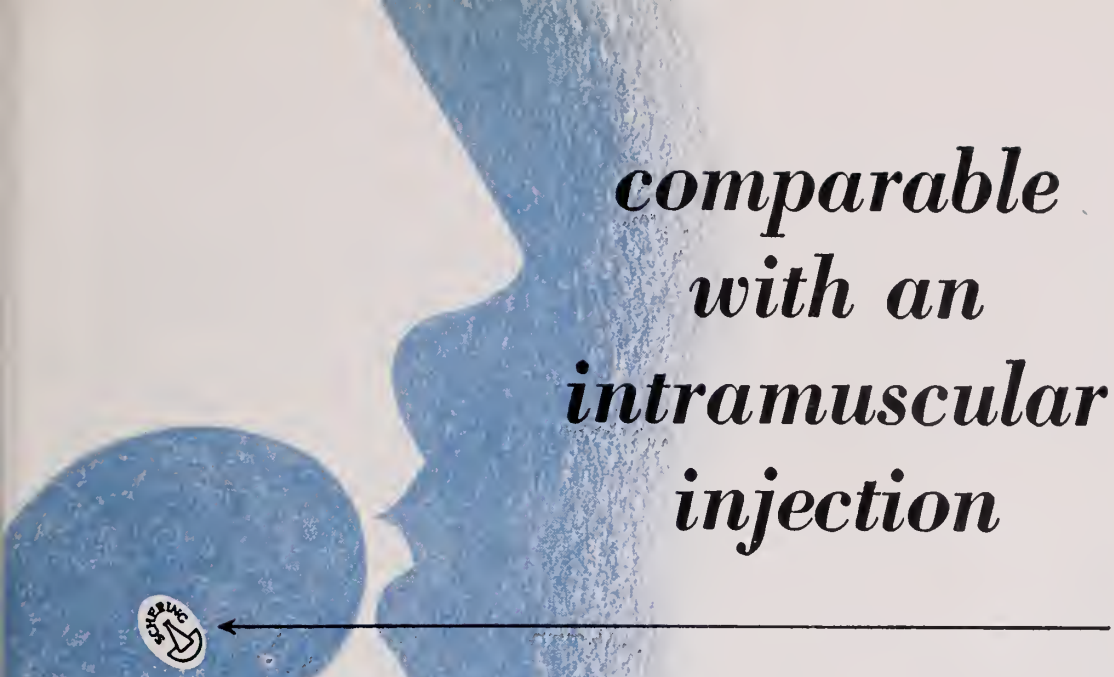
The prime importance in the treatment is early tracheotomy. It offsets laryngeal spasm and allows suction of secretions, thus avoiding pulmonary complications. Patient is put to rest in a darkened room, and given sodium luminol I.M. This patient was given 400,000 units of tetanus antitoxin. Foley catheter was inserted to prevent retention and to record the daily output. Patient was given 2000 cc D W plus 1000 cc normal saline daily. The tracheotomy tube was removed on the 13th day.

Dr. Mulroy then reported on 15 cases of tetanus at Rhode Island Hospital out of 220,000 admissions. 4 of the 15 were seen by the local medical doctor at the time of injury. Incubation period was 4-19 days. Trismus was the first symptoms in all cases. None of these cases had received prophylactic injections. Four of the 5 patients that died, died in 36 hours after receiving antitoxin. All presented a picture of cerebral edema and hyperpyrexia. He feels the high temperature was caused by the antitoxin, and the patients died on this rather than the disease. 5 of the 15 cases received penicillin. One burn case developed tetanus while on prophylactic penicillin. 60-70% of the cases sustain fractures of the vertebrae. He feels tracheotomy is indicated in every case. Further treatment includes sedation and penicillin. Too much antitoxin should not be used e.g. only 1500 units with some around the wound, and then 1500 units I.M. for 2-3 days.

The second guest speaker was Mr. Elisha C. Mowry, an attorney, the president of the Rhode Island Branch, English-Speaking Union, who from personal experience discussed "Socialized Medicine in Great Britain," as observed by him on a visit to England.

Mr. Mowry discussed the background facts that lead to the present trend in Socialized Medicine. A great world wide revolution exists in all the countries, more of a social trend toward the age of common man. We are getting wealthy distribution through taxation,—a creeping socialism.

continued on page 676



comparable with an intramuscular injection

Simple, practical and convenient, Schering's BUCCAL Tablets offer "parenteral hormone therapy by mouth" with little sacrifice of potency. Dissolved in POLYHYDROL* base, a solid solvent, the steroid hormones are absorbed directly from the oral mucosa. Early hepatic inactivation is obviated permitting a clinical effect "by mouth" comparable with that of an intramuscular injection.

BUCCAL TABLETS

Indicated in adrenal insufficiency—**CORTATE**® Buccal Tablets;
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in the menopausal syndrome—**PROGYNON**® Buccal Tablets;
in habitual abortion—**PROLUTON**® Buccal Tablets.

Packaging: CORTATE Buccal Tablets (Desoxycorticosterone Acetate U.S.P.) 2 mg.; ORETON Buccal Tablets (Testosterone Propionate U.S.P.) 2.5 and 5 mg.; PROGYNON Buccal Tablets (Estradiol U.S.P.) 0.125 and 0.25 mg. and PROLUTON Buccal Tablets (Progesterone U.S.P.) 10 mg. — in bottles of 30 and 100.

*T.M.

Schering CORPORATION
BLOOMFIELD, N. J.

BUCCAL TABLETS

SCHERING

PROVIDENCE MEDICAL ASSOCIATION

continued from page 674

Here in the United States we have our "deals." In England, Socialized Medicine was the most prominent issue because it affected everybody. Socialized Medicine did not originate with the Labor Party. All three parties wanted some form of socialized medicine. Britain's economic and medical situation in 1945 was bad. England was virtually bankrupt. There was a great shortage of doctors, hospitals, and nurses. The National Health Service was brought out at a time of economic trouble and medical shortage.

Bevan wanted all the doctors to be agents of the state under the control of the Minister of Health. On the other side, the British Medical Association did not want this. They wanted fees based on ability instead of the same fees for all classes even though there were differences in ability. Certain concessions were granted by the government, so the doctors were given contracts with the state. After initial opposition, the doctors decided to try it out, so by October 1949, 19,000 general practitioners and 95% of all the British people had signed up. The maximum load was 4000 patients per doctor. The average was 2000-3000.

They did not add one doctor, nurse, or hospital bed, so a tremendous load was added to the already overloaded facilities. Thousands of abuses arose. There was a tendency for the doctor to take on too many patients. They also had a tremendous amount of paper work. The busy practitioner could not spend the time per patient so they "dumped" the problems on specialists and into hospitals. The hospitals were filled to capacity and overcrowding. Another bad feature was the fact that the consultants and specialists are too busy with committee work to see many patients. Individual attention is sloughed over. There is not sufficient difference in pay between good and mediocre men. There is the fear that initiative will be smothered.

He concludes that idealism was set up on an impractical basis,—too hurriedly constricted by inexperienced men. They took too big a step at the wrong time.

The cost of it all may sink Britain. Mr. Mowry feels it is here to stay as an accepted British institution. As time goes on, it may be more self sustaining.

The final paper, a case report on "Infectious Hepatitis Complicating Pregnancy," was presented by Dr. Leonard Sutton, resident of Rhode Island Hospital. Dr. Elihu S. Wing, Jr. formerly a resident at Rhode Island Hospital and presently a resident at Johns Hopkins Hospital, collaborated with Dr. Sutton in the preparation of the report.

Dr. Sutton presented an excellent talk on infectious hepatitis complicating pregnancy.

A case recently studied at the Rhode Island Hospital was admitted during her seventh month of pregnancy with weakness, nausea, and progressive jaundice of two weeks duration. Patient never had any injections or blood taken. Her urine darkened and stools became lightened. On physical, the blood pressure was 110/50, abdomen protuberant, uterus consistent with seventh month pregnancy. A non tender liver edge 2 cm. below the costal margin was felt. W.B.C. 12,000. Thymol turbidity 16, prothrombin time 48% of normal.

Patient was treated with bed rest, candy, low fat high vitamin diet. On the sixth day, she delivered a viable infant that was not icteric. Two days post partum, she became nauseated, jaundiced, and in two hours lapsed into a coma, with convulsive movements of the extremities. The abdomen was soft; the liver edge no longer palpable, and liver dulness was absent. Blood glucose dropped to 12 mg%. Acute hepatic insufficiency set in. Within two hours after I.V. glucose and 500 cc whole blood, patient could be roused. A constant infusion of glucose was started. The foremost factor in therapy was large amounts of I.V. glucose. She received 700 gms. in the first twenty-four hour period. The urine was free of sugar in spite of all this glucose. The I.V. fluids were discontinued in three days. The appetite gradually returned. Liver dulness returned to costal margin, and the prothrombin activity returned to 100%.

Zondek reported 29 cases of infectious hepatitis complicating pregnancy. They are divided into three classes,—the non icteric, moderately severe, and the acite fulminating cases.

The pathology is a general fulminating liver parenchymal destruction. A high carbohydrate diet may be life saving in all forms of the disease. Blood, plasma, and antibiotics also help. The liver has remarkable regenerative powers.

The meeting adjourned at 10:30 p. m.

Collation was served.

Attendance 74.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

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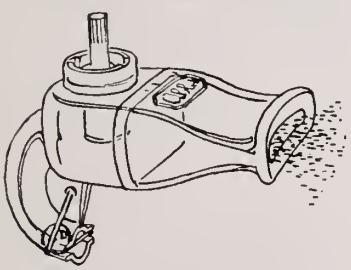
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1. Krasno, L. R., Grossman, M. I., and Ivy, A. C. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March. 2. Krasno, L. R., Grossman, M., and Ivy, A. C. (1948), The Inhalation of Norisodrine Sulfate Dust, Science, 108:476, Oct. 29.

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THE DOCTOR AND THE NATIONAL EMERGENCY

concluded from page 658

Some registrants who have indicated their desire to obtain a commission will also indicate their desire for a specific one of the services, namely the Army, Navy or Air Force. Ratios have been established by the Personnel Policy Board of the Office of the Secretary of Defense, which would allow the Army 70 percent of those applying for commissions, the Navy 10 percent and the Air Force 20 percent. As long as the vacancies are available within these percentages, individuals may obtain the service of their choice. After that, they must accept the service wherein vacancies exist or take their chances on induction.

Physician Quotas

You are all interested to know exactly what numbers of physicians are required for the armed forces in the current emergency. All of you realize that an answer is impossible at the present time, because none of us would be willing to predict the exact situation which confronts our Nation and the world during the months to come. All of us know that more physicians are required to support divisions in combat than those in training camps, and more physicians are needed to care for thousands of battle wounded than the ordinary ills of the same number of individuals. Many who write and speak professionally on world affairs are predicting frequent incidents during the years to come, such as we are now experiencing in Korea. The best we can do is to tell you that we constantly study requirements in view of the best prognostications of those with planning responsibility. Our basic staffing tables are revised in accordance with experience and the best professional knowledge in the world. Review bodies from civilian medicine have been established with the knowledge, advice, and sponsorship of The Surgeon General. With all these general facts in mind, the Army will probably require from civilian life during the next calendar year, somewhere in the neighborhood of 2,000 physicians. The Navy and the Air Force may together bring a similar number on duty.

It is not desired to dwell at length on the improvements that have been made in operating procedures since World War II. One notable advance, however, has been the development of a system whereby professional complements of units may be left at home when their units are brought to duty for training periods, with the understanding that they join the unit when it is assigned an operating mission. This is published in directive form and medical units brought to duty during the current emergency have reported without their professional complements.

The Reserve of the Future

To complete the picture, something must be said of the Reserve of the future. Committees of dis-

tinguished and sincere men have diligently studied this problem over the past few years, and the difficulties encountered in the relatively small mobilization we have just experienced should be proof positive that any policies that have thus far been developed are not panaceas to the ills of the reserve. More studies are in progress, and everyone is hopeful and desirous that a Reserve program will emerge that results in a firm foundation for the defense of the Nation and maximum satisfaction for the individuals participating therein.

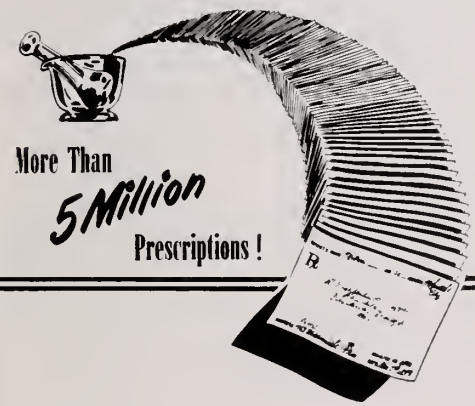
In summary, it is hoped that these remarks will have impressed you with the fact that that segment of American medicine within the armed forces is conducting itself creditably during the present emergency. The profession outside the armed forces can feel pride in this achievement, because it developed and fostered those in the service. It is hoped, furthermore, that these remarks may have clarified some of the questions that are confronting you daily and that they will contribute to a general belief that those of us in planning positions within the armed forces are attempting intelligent and sound approaches to the problems of the profession.

The physician in the current emergency must come to the realization that his profession must render support to the armed forces during their mobilization for the defense of our country and our way of life; that he should support and sponsor a strong, well-trained regular medical component in the armed forces to take as much of each initial impact as possible; that he should make his plans for his career to include at least one tour of duty in his Nation's armed forces; that he should impress all those entering the profession from the medical schools to so plan their personal careers so that a call of their country will not forever disrupt their professional lives; and last, that he must strive continuously to maintain a firm integration of military and civilian medicine in order that all segments of the profession may advance in harmony and in unison.

WASHINGTON COUNTY COMMITTEE

The Washington County Medical Society has named as its Professional Relations-Hospital Committee the following: Louis Cerrito, M.D., Chairman, of Westerly, Thomas A. Nestor, M.D., of Wakefield, and John M. O'Brien, M.D., of Wickford.

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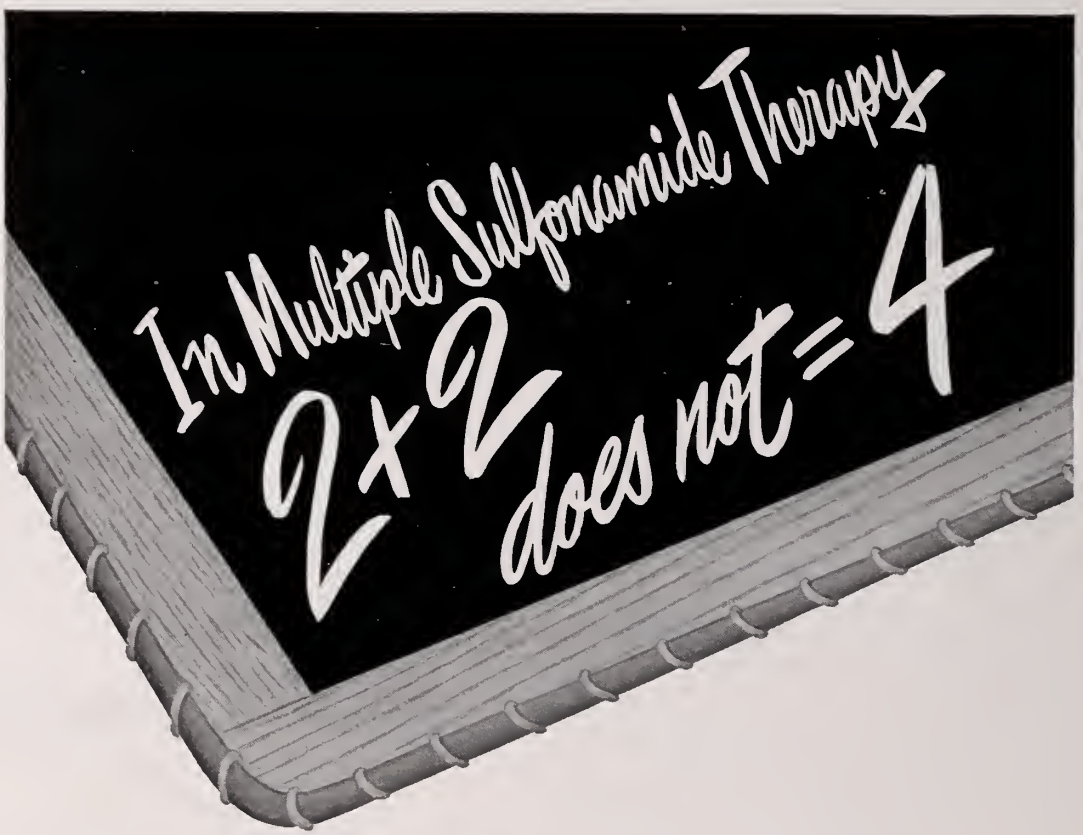
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1. Bargen, J. A.: Gastroenterology 13:275, 1949
2. Ivy, A. C., and Berman, A. L.: Minnesota Med. 22:815, 1939

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BALANCE SHEET — OCTOBER 31, 1950

ASSETS

	SEPT. 30, 1950	OCT. 31, 1950	INCREASE (DECREASE)
Cash in Banks and On Hand:			
Operating Account	$195,336.03	$224,716.30	$29,380.27
Treasurer's Account	1,000.00	1,000.00	—
Accounts Receivable (Subscriptions)	305.45	202.20	(103.25)
TOTAL ASSETS	$196,641.48	$225,918.50	$29,277.02

LIABILITIES

Accounts Payable (Surg.-Med. Service)	$ 37,808.00	$ 44,909.00	$ 7,101.00
Accounts Payable (Hosp. Serv. Corp.)	4,309.52	4,699.28	389.76
Accounts Payable (R. I. M. S.)	—	—	—
Accrued Surgical-Medical Expense	59,994.00	70,676.00	10,682.00
Unearned Subscriptions	4,880.70	4,508.60	(372.10)
TOTAL LIABILITIES	$106,992.22	$124,792.88	$17,800.66
Reserves:			
Surgical-Medical Expense	$ 89,649.26	$101,125.62	$11,476.36
TOTAL LIABILITIES AND RESERVES	$196,641.48	$225,918.50	$29,277.02

STATEMENT OF INCOME AND EXPENSES

	MONTH OF SEPT. 1950	%	MONTH OF OCT. 1950	%	TOTAL TO DATE 10/31/50	%
INCOME:						
Earned Subscriptions	$64,516.20	100	$71,916.64	100	$417,022.42	100
EXPENSES:						
SURGICAL-MEDICAL:						
Participating Physicians	$33,065.55	51.3	$48,301.00	67.2	$245,570.00	58.9
Non-Participating Physicians	6,498.00	10.0	7,290.00	10.1	38,502.00	9.3
Total	$39,563.55	61.3	$55,591.00	77.3	$284,072.00	68.2
OPERATING EXPENSES:						
Blue Cross under O.A.	$ 4,309.52	6.7	$ 4,699.28	6.5	$ 27,759.73	6.6
Direct Expenses (Auditing)	—		150.00	.2	1,917.29	.5
Organization Expense	—		—		2,147.78	.5
Total	$ 4,309.52	6.7	$ 4,849.28	6.7	$ 31,824.80	7.6
TOTAL EXPENSES	$43,873.07	68.0	$60,440.28	84.0	$315,896.80	75.8
NET INCOME ADDED TO RESERVES	$20,643.13	32.0	$11,476.36	16.0	$101,125.62	24.2

ENROLLMENT BY MONTHS

	CONTRACTS				SUBSCRIBERS				
MONTH	"S"	"C"	"D"	TOTAL	"S"	"C"	"D"	TOTAL	AVG. SUB. PER CONTR.
1 '50	1,418	3,844	6	5,268	3,844	7,996	16	11,856	2.25
2 '50	1,774	849	25	2,648	4,072	1,795	59	5,926	2.24
3 '50	2,351	1,108	38	3,497	6,007	2,283	76	8,366	2.39
4 '50	4,755	1,231	40	6,026	10,802	2,605	81	13,488	2.24
5 '50	2,183	2,910	110	5,203	5,169	6,762	249	12,180	2.34
6 '50	3,028	2,452	132	5,612	6,349	5,895	303	12,547	2.24
7 '50	1,432	2,131	53	3,616	3,289	4,938	121	8,348	2.31
8 '50	1,068	981	200	2,249	2,464	2,244	433	5,141	2.29
9 '50	1,153	1,792	151	3,096	2,584	3,688	348	6,620	2.14
10 '50	1,524	3,294	226	5,042	3,571	7,855	534	11,960	2.37
*11 '50	2,964	437	—	3,401	6,910	985	—	7,895	2.32
Net 11 1 50 (Before Cancellations)				44,313				102,354	2.31

* Preliminary Figure

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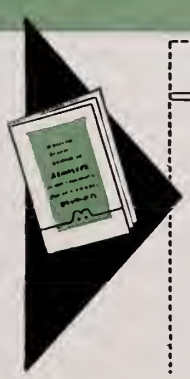
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1. Editorial: J.A.M.A. 141: 392 (1949).
2. Hueper, W. C.: M. Clin. North America 33: 773 (1949).



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BOOK REVIEWS

MEDICAL DIAGNOSIS. APPLIED PHYSICAL DIAGNOSIS. Edited by: Roscoe L. Pullen, M.D., F.A.C.P. W. B. Saunders Company. Second Edition. Philadelphia and London, 1950. $12.50.

The second edition of this well-accepted textbook of MEDICAL DIAGNOSIS presents methods of examination of the entire body through the regional approach and emphasizes the correlation of bedside observation and accessory diagnostic techniques. The new edition makes use of additional illustrations and color plates. The chapters dealing with the eye and abdomen have been rewritten, placing the emphasis on regional manifestations of disease. A discussion of modern laboratory tests of aid in the diagnosis of renal and liver disease have been added. The place of x-ray methods and the use of opaque materials is discussed. The discussion of electrocardiography has been revised to include the use of unipolar leads and basic principles of electrocardiography.

The second portion of the book has been altered, placing emphasis on diagnostic techniques. Chapters on military medicine and insurance prognosis have been deleted. The material in previous discussions of mental measurement, coma, and occupational injury have been either omitted or included in other discussions. A new chapter presents the pathologic physiology, signs and symptoms, and laboratory methods which allow one to recognize the various diseases of the blood. The book will be useful, not only for the student first learning diagnostic measures, but will increase the practicing physician's acumen in medical diagnosis. The esteem in which the previous edition was held may be evaluated by the simple fact that the copy in the Rhode Island Medical Library has been stolen. Experience has shown that only the better textbooks are thus honored.

RUSSELL P. HAGER, PH.D., M.D.

BREAST DEFORMITIES AND THEIR REPAIR by Jacques W. Maliniac, M.D. Grune & Stratton, Inc. N. Y., 1950. $10.00.

This small but unique textbook describes the work and knowledge of an experienced plastic surgeon regarding deformities of the breast and their repair. Dr. Maliniac reveals his two decades of experience in mammoplastic procedures from the days of Venus to the present. He definitely states that one must understand the anatomy, embryology, and physiology of the breast before undertaking reparative procedures. But with this knowledge as a background, one will, avoid unnecessary postoperative complications, both functional and aesthetic. The various deformities and the methods which have been used in correcting them are clearly outlined. Dr. Maliniac points out both the favorable and unfavorable procedures which have undergone the test of vast clinical experience, and describes those which are now in widespread use. The book also has many drawings and pictures that clarify the various procedures in mammoplasty.

BERT S. JEREMIAH, M.D.

TECHNIQUES IN BRITISH SURGERY. Edited by Rodney Maingot, F.R.C.S. W. B. Saunders Company, Philadelphia, 1950. $15.00

This volume is a selection of essays on various surgical subjects chosen somewhat at random. It is not intended to be in any sense a comprehensive presentation of general surgical techniques. It comprises thirty-two chapters by as many different authors. These skip rather haphazardly from The Management of Head Injuries in Civil Life to Spinal Tumors to Surgery of the Thyroid Gland, and so on. While it includes a chapter on mammaplasty, for example, there is nothing on carcinoma of the breast.

Each author has adhered to his own style without any attempt at uniformity or standardization in the handling of material. As is usual in British medical writings the text is lucid and delightfully

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readable. The illustrations which employ varied pictorial techniques are nevertheless unusually clear and helpful.

The Editor writes: "This book . . . is, I venture to hope, a liberal cross-section of British surgery as practiced today. It may be argued that the section should have been made more obliquely so as to include many more outstanding contributors and to ensure that the widest possible field had been covered. If this book fulfills the high hopes of popularity I confidently anticipate, then no doubt at some future date serial sections will be undertaken."

The reader is impressed by the very close similarity in methods presently employed in Britain and in America. While this may seem to make a book of this sort somewhat superfluous, it nevertheless adds assurance to the apparent world-wide trend toward standardization. Its place in the surgical literature is somewhat akin to Surgical Practice of the Lahey Clinic published a few years ago. It is certainly a pleasant addition to any surgical library and the advent of more "serial sections" in the future will enhance its usefulness.

SEEBERT J. GOLDOWSKY, M.D.

A TEXTBOOK OF GYNECOLOGY by Arthur Hale Curtis, M.D. and John William Huffman, M.D. W. B. Saunders Company, Philadelphia, 1950. $10.00

This standard work has been thoroughly revised and is published in its sixth edition with the aid of a junior author, John W. Huffman, M.D.

The chapters on Embryology and on Urinary Tract Problems in Gynecology show extensive revision. There is much new material particularly on ovarian tumors and dyspareunia.

The section on Pelvic Anatomy prepared in collaboration with Dr. Barry Anson continues to be a particularly fine presentation.

WILLIAM ALLEN REID, M.D.

PATHOLOGIC PHYSIOLOGY: MECHANISMS OF DISEASE. William A. Sodeman, editor. W. B. Saunders Company, Philadelphia, 1950. $11.50

This book is representative of a current trend toward collaborative authorship. The results in the present instance are pleasing from several standpoints: The contributions stem from 25 well-known authorities; the contents have been carefully selected and edited to prevent duplication of material; a timely advance has been made in the effort to interpret pathological conditions in the light of disturbed physiology.

The main sections include: The Circulatory, Respiratory, Digestive and Locomotor Systems; the Blood and Spleen; Urinary Tract; Endocrine

continued on next page

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Glands, Water Balance and Nutrition; Infectious Diseases and Allergy; Physical, Toxic and Chemical Agents. Each topic is generously supported with complete references.

The general outline resembles the usual text in physiology. The essential difference is that the material is significantly interspersed, correlated and augmented with the clinical picture of disease. While an apparent effort has been made to eliminate undue emphasis on etiology, symptoms and treatment, the considerable bulk of such descriptive material remaining is not detrimental. The book is recommended as a source of inspiration for all who are concerned with the rationale of disease.

WENDELL T. CARAWAY, PH.D.

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CIRCULATORY MANIFESTATIONS OF OBSTRUCTION OF THE SUPERIOR VENA CAVA

concluded from page 662

[6] Ehrlich, W., Ballon, H. C., Graham, E. A.: Superior Vena Cava Obstruction with Consideration of the Possible Relief of Symptoms by Mediastinal Decompression, *J. Thorac. Surg.*, Vol. 3, 352, 1934.

[7] Hinshaw, H. C., Rutledge, D. I.: Lesions in Superior Mediastinum which Interfere with Venous Circulation, *J. Lab. and Clin. Med.*, Vol. 27, 908, 1942.

[8] McIndoe, A. H.: Vascular Lesions of Portal Cirrhosis, *Arch. Path.*, Vol. 5, 23, 1928.

[9] Carlson, H. A.: Obstruction of the Superior Vena Cava in Experimental Study, *Arch. of Surg.*, Vol. 24, 669, 1934.

[10] Gray, H. K., and Skinner, I. C.: Constrictive Occlusion of the Superior Vena Cava; Report of three cases in which patients were treated surgically; *Surg., Gynec., and Obst.*, Vol. 72, 923, 1941.

[11] Ochsner, A., and Dixon, J. L., Superior Vena Caval Thrombosis: Review of the literature and report of cases of traumatic and infectious origin. *J. Thoracic Surg.*, Vol. 5, 641-672, 1936.

[12] Pearson, O. H., et al. A. C. T. H. and Cortisone—induced regression of lymphoid tumors in man, *Cancer*, Vol. 2, 943-945, 1949.

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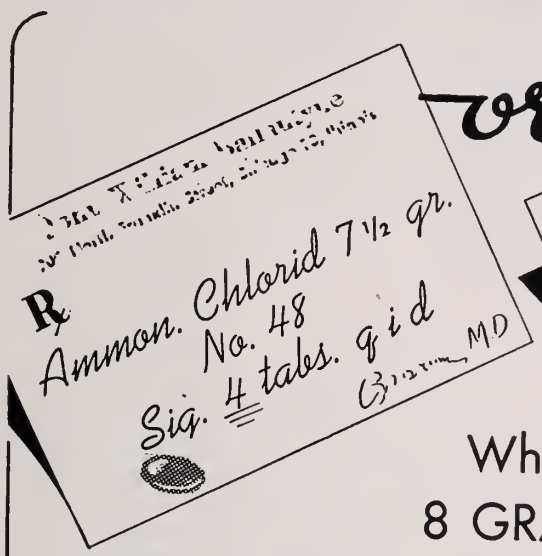


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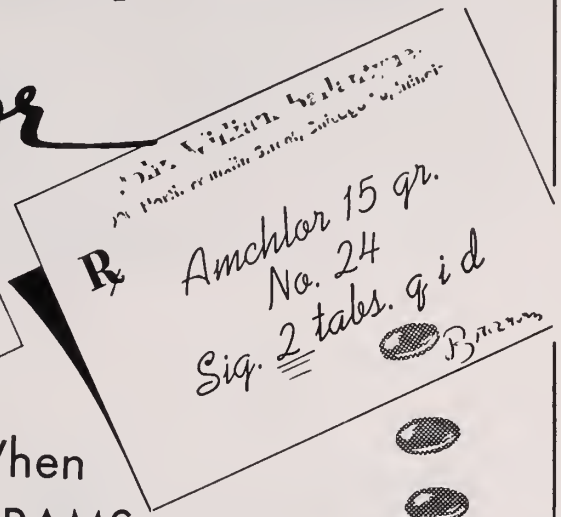
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